

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. Benedictine Health Center Innsbruck July 24, 2015 Pag&

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.

Benedictine Health Center Innsbruck July 24, 2015 Pag&

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

Karnyn Serie

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

SENDER: COMPLETE THIS SECTION Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 1. Article Addressed to: Ms. Susan Ager, Administrator Benedictine Health Center Innsbruck 1101 Black Oak Drive New Brighton, MN 55112 MDH L&C 3201 A. Signature X	PAT
within 5 day	/s
7008 0150 0001 1713 2347 TDK ML/Please return Within 3 day PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M	

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

NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK (PA) ID (ACH) DEFICIENCES (ACH) DEFICIENCIES (ACH) DEFICIENCIES (ACH) DEFICIENCIES (ACH) DEFICIENCIES (ACH) DEFICIENCIES (ACH) DEFICIENCY MUST BE PROCEDED BY PILL REGULATORY OR LISC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS The facility splan 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 plant of the process of the revisit of your facility may be cylindrate. Upon receipt of an acceptable accommodity validate that substantial companies in the regulations has been attained in a coronage with your verification. Revised 2567 as a result of an informat Dispuse Resolution F 225 SS=D 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 unfiltness for service as a nurse aide or other facility staff to the State nurse aide or other facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY TAG) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCY TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCY TO THE APPROPRIATE DEFICIENCY) PREFIX TAG F 000 INITIAL COMMENTS F 000 INITIAL COMMENTS F 000 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 verification of compliance upon the regulations has been attained in a sort once with your verification. Upon receipt of an acceptable NOS on op-site revisit of your facility may be conducted that substantial compliance in the regulations has been attained in a sort once with your verification. Revised 2567 as a result of an Informat Dispute Resolution Revised 2567 as a result of an Informat Dispute Resolution Revised 2567 as a result of an Informat Dispute Resolution Revised 2567 as a result of an Informat Dispute Resolution Revised 2567 as a result of an Informat Dispute Resolution Revised 2567 as a result of an Informat Dispute Resolution Revised 2567 as a result of an Informat Dispute Resolution Revised 2567 as a result of an Informat Dispute Resolution Revised 2567 as a result of an Informat Dispute Resolution Revised 2567 as a result of an Informat Dispute Resolution Revised 2567 as a result of an Informat Dispute Resolution Revised 2567 as a result of an Informat Dispute Resolution Revised 2567 as a result of an Information Revised 2567 as a result of an In			245310	B. WING			03/	26/2015
FREEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 PS-2567 form will be used as verification of corpolians. Upon receipt of an acceptable PSC in op-site revisit of your facility may be a inducted a validate that substantial compliance with the regulations has been attained in a zoro ace with your verification. Revised 2567 as a result of an Informat Dispute Resolution. Revised 2567 as a result of an Informat Dispute Resolution. 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 unfiltness for service as a nurse aide or other facility staff to the State nurse aide registry on corrections and the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations			ER INNSBRUCK		1	101 BLACK OAK DRIVE		
The facility's plan of correction (POC) will serve as your allegation of compilance upon the Department's acceptance. Your signature at the bottom of the first page of the CNS-2567 form will be used as verification of consoliance. Upon receipt of an acceptable SC on on-site revisit of your facility may be conducted to validate that substantial complance in the regulations has been attained in accordance with your verification. Revised 2567 as a result of an Informar Dispute Resolution Revised 2567 as a result of an Informar Dispute Resolution F 225 SS=D 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	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	(X5) COMPLETION DATE
as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the £ MS-2567 form will be used as verification of conditions. Upon receipt of an acceptable IND on on-site revisit of your facility may be onducted to validate that substantial compliance of the regulations has been attained in accordance with your verification. Revised 2567 as a result of an Informat Dispute Resolution 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 unifitness 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	F 000	INITIAL COMMEN	TS	F	000			
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	SS=D	as your allegation of Department's accellegation of the first place used as verificated. Upon receipt of an revisit of your facility validate that substate regulations has been your verification. Revised 2567 as a Resolution 483.13(c)(1)(ii)-(iii) INVESTIGATE/RE ALLEGATIONS/IN The facility must not been found guilty of mistreating resider had a finding enter registry concerning of residents or mistand report any known court of law against indicate unfitness of the facility staff to receive the facility must expressed in the facility of the too ther officials in through established.	of compliance upon the ptance. Your signature at the page of the CMS-2567 form will tion of convilance. acceptable DC in on-site ty may be conducted to antial compliance, which the en attained in accordance with a result of an Informar Dispute. The conviction of the property of abusing, neglecting, or antial by a court of law; or have red into the State nurse aide grabuse, neglect, mistreatment appropriation of their property; owledge it has of actions by a set an employee, which would for service as a nurse aide or the State nurse aide registry ities. Insure that all alleged violations anent, neglect, or abuse, of unknown source and of resident property are reported administrator of the facility and accordance with State law and procedures (including to the		225			

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.

04/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '	LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED	
		245310	B. WING	i	03	/26/2015
	PROVIDER OR SUPPLIER	ER INNSBRUCK		STREET ADDRESS, CITY, STATE, ZIF 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	² CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 225	The facility must haviolations are thore prevent further pot investigation is in put to the administrator epresentative and with State law (incle certification agency incident, and if the	ertification agency). ave evidence that all alleged bughly investigated, and must ential abuse while the		225		
	by: Based on intervier facility failed to ensure immediately (SA) for 2 of 8 alle reviewed. Findings include: R102's quarterly MR102 had a BIMS indicated R102 ha A facility Incident F1/28/15, R102 acc kneeling on her fether report was no 1/30/15, two days	w and document review, the sure all allegations of abuse reported to the state agency gations (R102, R200) **DS dated 2/16/15, revealed of 13 (cognitively intact), and d no history of hallucinations. Report Submission indicated on used an unidentified nurse of eding tube site during cares. t submitted to the SA until after the allegation was initially worker (SW)-A from a physical ber via email.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY MPLETED	
		245310	B. WING		03/	/26/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 225	R200's quarterly MR200 had a BIMS cognitive impairm symptoms. A Incident Tracking R200 had been for facility parking lot he was going to confreeway. The incident was not study on 9/8/14. During interview of director of social of abuse should be facility staff needed [reporting immeding interview of administrator. The until next day to resident was safed during the night, anotified immediation via text or email, were put on suspet the incident. During interview of director of nursing an allegation of a administrator immincident to the SA up to 24 hours to the SA. The DOI incident involving after it had happed and the same support in the same part of the same	MDS dated 12/5/14, revealed score of 12 (moderate ent) and no behavioral ag submitted to the SA indicated bund ward sing toward the on 9/3/4, all SB2 D had stated heck out the latio by the dent tracking indicated the	F 22			

	OF DEFICIENCIES F CORRECTION			(X3) DATE SURVEY COMPLETED			
		245310	B. WING			03/2	26/2015
	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE IEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	facility administrate immediately of alle she thought the fa report incidents to abuse or neglect vinitial report. The facility policy of dated 1/15, instruct should be immediated administrator. 483.13(c) DEVELOABUSE/NEGLECTOMESE/NEGLECTOMESE/NEGLECTOMESTREAMED The facility must of policies and proceduristreatment, negligible and misappropriated This REQUIREMED by: Based on interviet facility failed to improcedure related allegations of abuse of 8 allegations (Findings include: R102's quarterly of R102 had a BIMS	on 3/26/15, at 1:36 p.m. the constated she was notified egations of above, however, cility had up to 25 hours to the SA to as substantiated was suppected at the time of the citied Abuse where the plantited all allegations of above ately reported to the SA and the OP/IMPLMENT	F2	225			5/5/15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		E SURVEY MPLETED	
		245310	B. WING		03	/26/2015
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, Z 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 226	1/28/15, R102 acc kneeling on her fe The report was not 1/30/15, two days received by social therapy staff mem R200's quarterly MR200 had a BIMS cognitive impairms symptoms. A Incident Trackin R200 had been fot facility parking lot he was going to confreeway. The incident was not stay on 9/8/14. During interview of director of socials of abuse should be facility staff needed (reporting immedinursing staff generabuse to the DON administrator. The until next day to resident was safe during the night, anotified immediate via text or email, a were put on suspethe incident. During interview of the polarity of the polarity of the night, anotified immediate via text or email, a were put on suspethe incident.	Report Submission indicated on sused an unidentified nurse of eding tube site during cares. It submitted to the SA until after the allegation was initially worker (SV)-A com a physical ber via actual. MDS dated 1 15/14, recorded score of 12 mode at each in the submitted in the		226		

NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK SUMMARY STATEMENT OF DEFICIENCES (PART) RESULATORY OR LSC IDENTIFYING INFORMATION) F 226 Continued From page 5		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				OMPLETED	
BENEDICTINE HEALTH CENTER INNSBRUCK 110 BLACK OAK DRIVE NEW BRIGHTON, MM 55112 100,4102 PREFIX TAG 110 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) PREFIX TAG 110 PRE			245310	B. WING		100 49	03/2	26/2015
FREETX TAG FEGULATORY OR LSC IDENTIFYING INFORMATION) 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 incident involving R102 until 200 be of days after it had happened, and/st notified the administrator and SA whom she was unaware of the incident. During interview on 3/26/15, at 1.3 p.h., the facility administrator stated she was notified immediately of allegations of abuses to report incidents to the SA unless substantiaty abuse or neglect was suspected at the times 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 282 SS=D 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 falialed to ensure 1 of 1 resident (R95) reviewed for activities of daily living			ER INNSBRUCK		11	101 BLACK OAK DRIVE		
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 zook je of days after it had happened, and the jet of days after it had happened, and the jet of the incident involving R102 until zook je of days after it had happened, and the jet of the incident. During interview on 3/26/15, ax1:30 p.N. the facility administrator stated she was notified immediately of allegations of abuse sowever, she thought the facility had up to 24 hours to report incidents to the SA unless substantiated abuse or neglect was suspected at the times and 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 282 483.20(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	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
the care plan.	F 282	an allegation of about administrator immediately to 24 hours to rethe SA. The DON incident involving after it had happen administrator and sof the incident. During interview or facility administrator immediately of alles thought the fact report incidents to abuse or neglect winitial report. The facility policy the dated 1/15, instruct should be immediated administrator. 483.20(k)(3)(ii) SE PERSONS/PER CONS/PER	use she would call the ediately and then report the however, she stated she had eport allegations of abuse to stated she was unaware of the R102 until a course of days ed, and at a notine of the R102 until a course of days ed, and at a notine of the R102 until a course of days ed, and at a notine of the R102 until a course of the R102 until a		S			4/22/15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		E SURVEY IPLETED	
		245310	B. WING _	,	03/	26/2015
	PROVIDER OR SUPPLIER	TER INNSBRUCK		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	Continued From pa	age 6	F 28	2		
	Findings include:					
	3/21/15, indicated	nimum data set (MDS) dated R95 had morbrate cognitive equired extrasts assistance of coming as vities.				
	R95's care area as 9/23/14, indicated activities of daily liv muscle weakness.					
	diagnoses includir	ated 3/25/15, indicated R95 (ading tremor, muscular atroph), and required staff assistance				
	had a significant a under his chin and interview at this tir	n on 3/23/15, at 7:40 p.m. R95 mount of facial hair, especially d on the upper neck. During me, R95 stated he preferred to but needed staff to help him				
	was still unshaven	n on 3/24/15, at 9:17 a.m. R95 n. R95 stated it took them [staff] e to help him this morning and helped him to shave but, "I sure				
	was observed with upper neck and cl long. Nursing Ass his morning cares	n on 3/25/15, at 8:45 a.m. R95 on significant facial hair on the nin area, approximately 3/4" sistant (NA)-A assisted R95 with and did not offer R95 shaving leaving the room to assist other				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245310	B. WING			03/2	6/2015
	ROVIDER OR SUPPLIER	ER INNSBRUCK		110	REET ADDRESS, CITY, STATE, ZIP CODE 11 BLACK OAK DRIVE W BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282 F 312 SS=D	stated he wished s consistently, and h trimmed. During interview or stated R95 should shaving on a daily was broken so starazor to shave R95 During interview or registered nurse (Find the director of nursing shaving assistance available for use. Facility policies reliever requested, by 483.25(a)(3) ADL DEPENDENT RESTATES A resident who is a daily living receive maintain good nut and oral hygiene. This REQUIREMED by: Based on observative with the facility (R95) reviewed for received assistance.	in 3/25/15, at 9:47 a.m. R95 taff would shave him e wanted his facial hair in 3/25/15, at 9:48 a.m. NA-A be offer a assistance with basic and in electric razor ff needed to use a structure. in 3/25/15, at 9:4 a.m., RN)-C, who was the assistance attended at a structure at a structure. in 3/25/15, at 9:4 a.m., RN)-C, who was the assistance attended at a structure. in 3/25/15, at 9:4 a.m., RN)-C, who was the assistance attended at a structure. in 3/25/15, at 9:4 a.m., RN)-C, who was the assistance at a structure. in 3/25/15, at 9:4 a.m., RN)-C, who was the assistance at a structure. in 3/25/15, at 9:4 a.m., RN)-C, who was the assistance at a structure. in 3/25/15, at 9:4 a.m., RN)-C, who was the assistance at a structure at a structure. in 3/25/15, at 9:4 a.m., RN)-C, who was the assistance at a structure. in 3/25/15, at 9:4 a.m., RN)-C, who was the assistance at a structure. In 3/25/15, at 9:4 a.m., RN)-C, who was the assistance at a structure. In 3/25/15, at 9:4 a.m., RN)-C, who was the assistance at a structure. In 3/25/15, at 9:4 a.m., RN)-C, who was the assistance at a structure. In 3/25/15, at 9:4 a.m., RN-A In	F	312			4/22/15
	Findings include:						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245310	B. WING			03/2	26/2015
	PROVIDER OR SUPPLIER	FER INNSBRUCK		11	REET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE EW BRIGHTON, MN 55112	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	R95's quarterly min 3/21/15, indicated impairment, and re one staff for all grown R95's care area as 9/23/14, indicated activities of daily limuscle weakness. R95's care plan dadiagnoses includin difficulty walking, a with shaving daily. During observation had a significant a under his chin and interview at this timble clean shaven be shave. During observation was still unshaven "Forever," to come staff had still not hwish they would." During observation was observed with upper neck and chlong. Nursing Asshis morning cares assistance before residents. During interview of stated he wished stated he wished.	nimum data set (MDS) dated R95 had moderate cognitive equired extensive assistance of coming activities. Seessment CAN dated R95 ners of assistance in all ving in audin arrowning due to ated 3/25/15, indicate R95 had ag tremor, must flar atro-hy, and required staffn essistance		312			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245310	B. WING			03/2	26/2015
	ROVIDER OR SUPPLIER	ER INNSBRUCK		1	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE IEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From patrimmed.		F:	312			
	stated R95 should shaving on a daily l	n 3/25/15, at 9:48 a.m. NA-A be offered assistance with basis, and his electric razor f needed to use a straight is.					
	registered nurse (F director of nursing,	n 3/25/15, at 9:54 a.m., RN)-C, who was the cassis ant stated R95 should by offered e daily and R95 and razers					
F 323 SS=D	Facility policies rela were requested, bu 483.25(h) FREE O HAZARDS/SUPEF	F ACCIDENT	F				4/3/15
	environment remai as is possible; and	nsure that the resident ins as free of accident hazards each resident receives ion and assistance devices to					
	by: Based on observareview, the facility were in compliance Administration (FD	NT is not met as evidenced ation, interview, and document failed to ensure bed side rails with Food and Drug (A) requirements to minimize tent, for 1 of 1 resident (R291) all safety.					
	Findings include:						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	IPLE CONSTRUCTION NG		E SURVEY IPLETED	
		245310	B. WING _		03.	/26/2015
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Continued From բ	page 10	F 3	23		
	3/17/15, identified cognition and req most activities of mobility and trans R291's care plan resident had bilat the bed), one-hal assist R291 with R291's Restraints assessment date including chronic (COPD), general status post rehab assessment iden one-half side rails from COPD, and with bed mobility assessment lack were evaluated to risk for entrapmed During observtion bilateral, half, med R291's bed, with against the wall observed tilted do 30 degrees from the bed. The rail from the bed, at degrees from the the rail. The space the rail to the market wall to the wall to the market wall to the market wall to the wall to	dated 3/20/11 indicates he eral (two, one on each side of side rails which ere used to bed mobility and positioning. s/Adaptive Equipment d 3/10/15, indicated diagraces obstruction pulmonary disease ized pain, a history of falls, and oilitation procedure. The tified R291 required two, is to his bed, related to weakness for increased independence and/or transfers. The ed any indication the side rails to be safe for R291, to reduce the				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION ING	(X:	(X3) DATE SURVEY COMPLETED	
		245310	B. WING	Name of the contract of the co		03/26/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIA		
F 323	half inches. Upon and maneuverable and perpendicular even greater space the room at the tin During interview of director of nursing had been like this years and years." dialing a black know it was affixed to the not be tightened a bedframe as the hattempting to tight the rail remained a spacing in zone sin half inches, which entrapment. On 3/24/15, at 9:3 was very loose an and felt they were to pull on that thin maneuvered the sperpendicular to the youthink it's going. During interview of DON, facility admiservices director of stated the side rail safety spentrapment, and the facility beds and checked rout.	manipulation, the rail was loose e, with movement both parallel to the mattress, allowing for ing at zone six. R291 was not inne of this observation. n 3/23/14, at 1:07 m. the (DOM state R2) 's siderails	F3	323			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	TIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		245310	B. WING		0	3/26/2015
	PROVIDER OR SUPPLIER	ER INNSBRUCK		STREET ADDRESS, CITY, STATE, ZIP O 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 323	no longer tilted out tighten the black k the bed frame, limi rail and setting the in acceptable space. Review of the facil safety audits indicated admission to the fa aspects of the side just indicated, "Eve The facility's Adapt 1/15, indicated, "The facility's Adapt 1/15, indicated, "The space between all reduce the risk for safe space may varied bed and mattress beds and mattress beds and mattress purchased and inschecked annually, change and PRN to the adaptive equency to the adaptive equency to the adaptive equency to the safety. The goopenings in the best than four and three risk of head entrait defined zone six and the safety.	ail parallel to the bed so it was ward, and she was able to nob, securing the rail firmly to ting the maneuverability of the rail in a manner which resulted ing for zone six. Ity's room ministerance and ated the side rail on Food's bed on 2/25/15 brior to R29 is cility. The audit of his specify erail which were examined an erything checked but." Itive Equipment policy date mattress and side rails to entrapment (the amount of the entrapment (the amount of the entrapment) in New models of the era eassessed if they are talled Residents are quarterly, with significant as needed] for safety relative	F3			
F 356 SS=C	483.30(e) POSTE	D NURSE STAFFING	F:	356		4/1/15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245310	B. WING			03/2	26/2015	
	PROVIDER OR SUPPLIER	ER INNSBRUCK		11	REET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE EW BRIGHTON, MN 55112	· in vari		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 356	The facility must per a daily basis: o Facility name. o The current date o The total number by the following care unlicensed nursing resident care per series and reading resident care per series and reading resident census. The facility must perspecified above or of each shift. Data or Clear and reading of line a prominent persidents and visite. The facility must, a make nurse staffir for review at a cosstandard. The facility must metallity must met	e and the actual hours worked regories of cell ed and staff die Ny responsible for hift: arses. ctical nurse or licrosed (as defined and staff glaw). e aides. cost the nurse staffing data a daily basis at the beginning must be posted as follows: cole format. lace readily accessible to	F	356				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION DING			TE SURVEY MPLETED	
		245310	B. WING			03	/26/2015	
	PROVIDER OR SUPPLIE			1101 BL	ADDRESS, CITY, STATE, ZIP CODE ACK OAK DRIVE BRIGHTON, MN 55112			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 356	Findings include: During initial tour 12:59 p.m. the fa Form dated 3/23/ bulletin boards at Transitional Care Village Unit. The designated for no shift were left bla not listed anywhe During interview information coord main employee r of the facility's No stated on weekd a.m., she looked electronic medica with the overnigh whether there we hours for the day forms based on on the bulletin boa HIC stated at the determined whet census or the so shift, and made to the posting befor HIC stated the cl shift was respon schedule change end of their shift nurses for each updating the form schedule informa	of the facility on 3/23/15, at cility's Nursing Service Hours (15, was observed affixed to the the entrance of whoth the Unit (TCT), and the Pioneer section of each for notation of the census decay each nk and the facility cares us was		356				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245310	B. WING	-		03/:	26/2015
	PROVIDER OR SUPPLIER			110	REET ADDRESS, CITY, STATE, ZIP CODE 01 BLACK OAK DRIVE EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 356	The facility census posting for eight of The facility census until the end of the eight out of 80 day. The facility's Nurs accurately posted On 3/24/15, at 3:1 days where the recorresponded with was gone on vacasome difficulty with the second of the control of the facility of the facility of the facility is a second of the facility	age 15 s was not identified on the ut of 80 days, or 10% of days. s was not added to the posting e evening shift, for an additional ys, or 10% of days. ing Service votes Forms were for less as a 80% of days. 5 p.m. HIC stated mouse the port was inaccurate n weekends and to days she ation. HIC states she was having h ensuring the postings were e was not available.	F	356			

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION	(X3) DATE SURVEY COMPLETED	
		245310	B. WING			03/	26/2015
	PROVIDER OR SUPPLIER	ER INNSBRUCK		1101 BL	ADDRESS, CITY, STATE, ZIP CODE ACK OAK DRIVE RIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 000		TS of correction (POC) will serve of compliance upon the	FO	00			
	bottom of the first p be used as verifcat	ptance. Your signature at the page of the CMS-2567 form will tion of corpoliance. acceptable 260 in on-site					
	revisit of your facili validate that substa regulations has be your verification.	ty may be conducted to antial compance of the en attained in a coronnee with					
F 225 SS=D	Resolution 483.13(c)(1)(ii)-(iii)	PORT		225			5/5/15
	been found guilty of mistreating resider had a finding enter registry concerning of residents or mist and report any known court of law against indicate unfitness.	ot employ individuals who have of abusing, neglecting, or abusing, neglecting, or abuse, neglect, mistreatment appropriation of their property; wiledge it has of actions by a st an employee, which would for service as a nurse aide or the State nurse aide registry ities.					
	involving mistreatr including injuries of misappropriation of immediately to the to other officials in through established	nsure that all alleged violations nent, neglect, or abuse, of unknown source and of resident property are reported administrator of the facility and accordance with State law of procedures (including to the					
LABORATOR	V DIRECTOR'S OR PROV	DEB/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

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

04/17/2015

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILE		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245310	B. WING			03/2	26/2015
	ROVIDER OR SUPPLIER	ER INNSBRUCK		11	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	violations are thoroprevent further pote investigation is in p The results of all in to the administrato representative and with State law (incl certification agency incident, and if the appropriate correct This REQUIREME by: Based on interview facility failed to enswere immediately in (SA) for 2 of 8 alleg reviewed. Findings include: R102's quarterly MR102 had a BIMS indicated R102 had a BIMS indicated R102 had A facility Incident F1/28/15, R102 acc kneeling on her feather eport was no 1/30/15, two days	ertification agency). ave evidence that all alleged aughly investigated, and must ential abuse while the erogress. Investigations cause on reported to other officials in accommoduling to the Starts as vey and (v) within 5 working days of the alleged violation averified time action must be taken. In and document review, the sure all allegations of abuse reported to the state agency gations (R102, R200) IDS dated 2/16/15, revealed of 13 (cognitively intact), and dono history of hallucinations. Report Submission indicated on used an unidentified nurse of eding tube site during cares. It submitted to the SA until after the allegation was initially worker (SW)-A from a physical	F	2225			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		245310	B. WING	i	03	/26/2015
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, Z 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 225	R200's quarterly R200 had a BIMS cognitive impairn symptoms. A Incident Tracki R200 had been f facility parking lo he was going to freeway. The incident was not day on 9/8/14. During interview director of social of abuse should facility staff need [reporting immed nursing staff gen abuse to the DO administrator. The until next day to resident was saf during the night, notified immediate via text or email, were put on sust the incident. During interview director of nursing an allegation of administrator imincident to the Sup to 24 hours to the SA. The DC incident involving after it had happens and the same support of	page 2 MDS dated 12/5/14, revealed 5 score of 12 (moderate nent) and no behavioral Ing submitters of the SA indicated ound warraking toward the ton 9/244, and B2 0 had stated check out the latio by the cident tracking indicated the submitted to the Sa their the reported immediately, as led to "Get sharper on that diately]." The DSS stated the reported allegations of N, who immediately notified the nerally reported allegations of N, who immediately notified the nerally and the administrator was tely at time of the verbal report and any alleged perpetrators bension pending investigation of on 3/26/15, at 1:36 p.m. the neg (DON) stated if she received abuse she would call the mediately and then report the A, however, she stated she had or report allegations of abuse to the stated she was unaware of the g R102 until a couple of days tened, and had notified the d SA when she was made aware		225		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONST	TRUCTION		(X3) DATE SURVEY COMPLETED	
		245310	B. WING			03/	26/2015	
	PROVIDER OR SUPPLIER	ER INNSBRUCK		1101 BLA	NDRESS, CITY, STATE, ZIP CODE ACK OAK DRIVE RIGHTON, MN 55112			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 225 F 226 SS=D	of the incident. During interview or facility administrator immediately of alle she thought the face report incidents to abuse or neglect winitial report. The facility policy to dated 1/15, instruct should be immediated administrator. 483.13(c) DEVELOABUSE/NEGLECT The facility must depolicies and proceemistreatment, negliand misappropriation. This REQUIREMED by: Based on interview facility failed to improcedure related allegations of abus of 8 allegations (Refindings include: R102's quarterly Medical R102's q	in 3/26/15, at 1:36 p.m. the or stated she was notified gations of abose, however, cility had up to 2% hours to the SA 2000 ss substantiated was supperticulative time of the citled Abuse virey with Planted all allegations of abose ately reported to the SA and the DP/IMPLMENT T, ETC POLICIES	F	25			5/5/15	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		245310	B. WING		03	/26/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 226	1/28/15, R102 acc kneeling on her fe The report was not 1/30/15, two days received by social therapy staff mem R200's quarterly R200 had a BIMS cognitive impairm symptoms. A Incident Tracking R200 had been for facility parking lot he was going to confreeway. The incident was not staff of abuse should be facility staff needs [reporting immediation of abuse to the DON administrator. The until next day to resident was safe during the night, anotified immediation via text or email, were put on susp the incident.	Report Submission indicated on cused an unidentified nurse of eding tube site during cares. It submitted to the SA until after the allegation was initially worker (SW)-A com a physical aber via a stall. MDS dated 11.5/14, rescaled score of 12 modes (e)		226		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245310	B. WING		03/	26/2015	
	ROVIDER OR SUPPLIER	ER INNSBRUCK		STREET ADDRESS, CITY, STATE, ZIP CODI 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 282 SS=D	administrator immerincident to the SA, up to 24 hours to rethe SA. The DON incident involving Fafter it had happen administrator and Softhe incident. During interview or facility administrator immediately of alleshe thought the factor report incidents to abuse or neglect winitial report. The facility policy to dated 1/15, instructional should be immediated administrator. 483.20(k)(3)(ii) SE PERSONS/PER Community to provided to accordance with excare. This REQUIREMED by: Based on observative with facility for the service of the the ser	use she would call the ediately and then report the however, she stated she had eport allegations of abuse to stated she was unaware of the R102 until a couple of days ed, and a dinoting the RA whom she was hade aware of 3/26/15, ax1:32 p.h. the or stated she was notified gations of abuse, sowever, cility had up to 24 hours to the SA unless substantiated was suspected at the time of the dil allegations of abuse ately reported to the SA and the RVICES BY QUALIFIED	F 2			4/22/15	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ''		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245310	B. WING			03/2	26/2015
	PROVIDER OR SUPPLIED			11	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	Findings include: R95's quarterly m 3/21/15, indicated impairment, and none staff for all gr R95's care area a 9/23/14, indicated activities of daily muscle weakness R95's care pland diagnoses includidifficulty walking, with shaving daily During observation had a significant under his chin an interview at this tibe clean shaven shave. During observation was still unshave "Forever," to comstaff had still not wish they would."	inimum data set (MDS) dated R95 had morbrate cognitive required extrastive assistance of coming a vittles. Assessment (AA) data R95 needed assistance in all living including growning due to s. Idated 3/25/15, indicated R95 rading tremor, muscular atrophy, and required staff assistance. In on 3/23/15, at 7:40 p.m. R95 amount of facial hair, especially don the upper neck. During time, R95 stated he preferred to but needed staff to help him In on on 3/24/15, at 9:17 a.m. R95 n. R95 stated it took them [staff] the to help him this morning and helped him to shave but, "I sure		282		RIATE	DATE
	was observed wit upper neck and o long. Nursing As his morning care	th significant facial hair on the chin area, approximately 3/4" sistant (NA)-A assisted R95 with s and did not offer R95 shaving be leaving the room to assist other					

		IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245310	B. WING		03/26/2015		
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK				STREET ADDRESS, CITY, STATE, ZIP O 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE	
F 282 F 312 SS=D	stated he wished sconsistently, and he trimmed. During interview of stated R95 should shaving on a daily was broken so start razor to shave R9 During interview of registered nurse (director of nursing shaving assistance available for use. Facility policies rewere requested, by 483.25(a)(3) ADL DEPENDENT REAR A resident who is daily living receives maintain good nursing and oral hygiene. This REQUIREMING. This REQUIREMING.	n 3/25/15, at 9:47 a.m. R95 staff would shave him he wanted his facial hair on 3/25/15. 9:48 a.m. NA-A be offer a assistance with basis and help tric razor aff needed to use a straight 5. on 3/25/15, at 9:4 a.m., RN)-C, who was he assistance as deally and R95 should be offered be daily and R95 had razors of a straight but not provided. CARE PROVIDED FOR SIDENTS unable to carry out activities of es the necessary services to trition, grooming, and personal entertains and document failed to ensure 1 of 1 resident or activities of daily living	F2	312		4/22/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245310		B. WING			03/26/2015	
	PROVIDER OR SUPPLIER	ER INNSBRUCK		11	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE IEW BRIGHTON, MN 55112	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	3/21/15, indicated impairment, and re one staff for all gro R95's care area as 9/23/14, indicated activities of daily live muscle weakness. R95's care plan dadiagnoses includin difficulty walking, a with shaving daily. During observation had a significant at under his chin and interview at this tim be clean shaven b shave. During observation was still unshaven "Forever," to come staff had still not hwish they would." During observation was observed with upper neck and chlong. Nursing Ass his morning cares assistance before residents. During interview of stated he wished sta	nimum data set (MDS) dated R95 had moderate cognitive quired extensive assistance of oming activities. Seessment CAN dated R95 nearly assistance in all ving it studing growning due to		312			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED
		245310	B. WING			03/2	26/2015
	ROVIDER OR SUPPLIER	ER INNSBRUCK		11	FREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	stated R95 should shaving on a daily was broken so stat razor to shave R95	n 3/25/15, at 9:48 a.m. NA-A be offered assistance with basis, and his electric razor if needed to use a straight 5.	F:	312			
F 323 SS=D	registered nurse (F director of nursing, shaving assistance available for use. Facility policies rel- were requested, but 483.25(h) FREE O		F				4/3/15
	environment rema as is possible; and	nsure that the resident ins as free of accident hazards I each resident receives ion and assistance devices to					
	by: Based on observareview, the facility were in complianc Administration (FE the risk of entraphreviewed for side in the side of the side	eNT is not met as evidenced ation, interview, and document failed to ensure bed side rails e with Food and Drug DA) requirements to minimize nent, for 1 of 1 resident (R291) rail safety.					
	Findings include:						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245310	B. WING			03/26/2015	
	PROVIDER OR SUPPLIER			11	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE IEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	Continued From p	age 10	F	323			
	3/17/15, identified cognition and request activities of comobility and transfer R291's care plan coresident had bilated the bed), one-half	dated 3/20/13 indicates the eral (two, on on each side of		•			
	assessment dated including chronic (COPD), generalized status post rehabited assessment identione-half side rails from COPD, and the with bed mobility assessment lacket	Adaptive Equipment 3/10/15, indicated diagnoss obstruction pulmonary disease zed pain, a history of falls, and litation procedure. The ified R291 required two, to his bed, related to weakness for increased independence and/or transfers. The ad any indication the side rails be safe for R291, to reduce the int.	(
	bilateral, half, met R291's bed, with t against the wall. T observed tilted do 30 degrees from t the bed. The rail a from the bed, at a degrees from the the rail. The space the rail to the mat	on 3/23/15, at 1:05 p.m. al side rails were raised on he far side of the bed flush. The outward-facing side rail was wn at an angle of approximately the head of the bed to the foot of also angled outward, lying away in angle of approximately 15 top of the rail to the bottom of the bed to the head of the bed as greater than seven and one					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245310	B. WING			03/2	26/2015
	PROVIDER OR SUPPLIER	ER INNSBRUCK		1101	ET ADDRESS, CITY, STATE, ZIP CODE BLACK OAK DRIVE ' BRIGHTON, MN 55112		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 323	and maneuverable and perpendicular even greater spacithe room at the time. During interview or director of nursing had been like this dyears and years." dialing a black kno it was affixed to the not be tightened as bedframe as the hattempting to tightened as bedframe as the hattempting to tighte the rail remained to spacing in zone six half inches, which entrapment. On 3/24/15, at 9:39 was very loose and felt they were, to pull on that thing maneuvered the siperpendicular to the you think it's going. During interview of DON, facility admits services director (I stated the side rail. The DON, facility at they were familiar side rail safety spaentrapment, and the facility beds an and checked routing the side routing the side routing the safety spaentrapment, and the facility beds an and checked routing the side routing the safety spaentrapment, and the facility beds an and checked routing the side routing the safety spaentrapment, and the facility beds an and checked routing the side routing the safety spaentrapment, and the facility beds an and checked routing the safety spaentrapment the safety spaentr	manipulation, the rail was loose, with movement both parallel to the mattress, allowing for at zone six. R291 was not in e of this observation. 1.3/23/14, 1.107, m. the (DON state R20) 's siderails	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245310		B. WING		03/	26/2015	
	ROVIDER OR SUPPLIER	ER INNSBRUCK		STREET ADDRESS, CITY, STATE, ZIP COD 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		IOULD BE	(X5) COMPLETION DATE	
F 323	while she set the rano longer tilted out tighten the black kr the bed frame, limi rail and setting the in acceptable space. Review of the facility safety audits indicated admission to the facility safety audits indicated, "Ever aspects of the side just indicated, "Ever The facility's Adapt 1/15, indicated, "The space between all reduce the risk for safe space may vare bed and mattress but and mattress purchased and inschecked annually, change and PRN [to the adaptive equilibration to the adaptive equilibration to the properties of the properties of head entrapticed and three risk of head entrapticed and the side the rail and the side the properties of	ail parallel to the bed so it was ward, and she was able to nob, securing the rail firmly to ting the maneuverability of the rail in a manner which resulted ing for zore six. Ity's room minterance and sted the side rail on P. It's bed on 2/25/15 brior to 129 is cility. The audit of in the specify rail which were examined an erything checked but." Ive Equipment policy date he facility has assessed to entrapment (the amount of rry, depending on the type of being used) New models of es are assessed if they are stalled Residents are quarterly, with significant as needed] for safety relative	F3	323			
F 356 SS=C	i .'	O NURSE STAFFING	F:	356		4/1/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		245310	B. WING _		03/:	26/2015	
	PROVIDER OR SUPPLIER	ER INNSBRUCK		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 356	The facility must por a daily basis: o Facility name. o The current date. o The total number by the following cat unlicensed nursing resident care per s - Registered nu Licensed pract vocational nurses (- Certified nurse or Resident census) The facility must pust persident above on of each shift. Data or Clear and readat or In a prominent place of the facility must, unake nurse staffing for review at a cost standard. The facility must must must fing data for a required by State later the facility must must fing data for a required by State later the facility must must fing data for a required by State later the facility must must fing data for a required by State later the facility must must fing data for a required by State later the facility current census information of the facility current census information of the facility current census information of the facility current census information.	and the actual hours worked regories of cell ed and staff did by responsible for hift: brees. ctical nurse or licrosed as defined and a State law). e aides. cost the nurse staffing data a daily basis at the beginning must be posted as follows: cole format. acc readily accessible to	F 35				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
245310		B. WING	i	03.	/26/2015		
	PROVIDER OR SUPPLIER CTINE HEALTH CEN			STREET ADDRESS, CITY, STATE, ZIP CO 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE	
F 356	Findings include: During initial tour of 12:59 p.m. the fact Form dated 3/23/2 bulletin boards at Transitional Care Village Unit. The state designated for not shift were left blar not listed anywher the facility's Nu stated on weekda a.m., she looked electronic medica with the overnight whether there we hours for the day forms based on the on the bulletin boat HIC stated at the determined whether census or the sch shift, and made the posting before HIC stated the ch shift was respons schedule changes end of their shift, nurses for each supdating the form schedule informat.	of the facility on 3/23/15, at cility's Nursing Service Hours 15, was observed affixed to the the entrances of both the Unit (TC), and the Pioneer sections of each from tation of the consus during each ak and the facility cassus was	F	356			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		245310	B. WING		03/:	26/2015
	PROVIDER OR SUPPLIER	ER INNSBRUCK		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE
F 356	The facility census posting for eight ou The facility census until the end of the eight out of 80 days. The facility's Nursir accurately posted f On 3/24/15, at 3:15 days where the rep corresponded with was gone on vacat	was not identified on the t of 80 days, or 10% of days. was not added to the posting evening shift, for an additional s, or 10% of days. In Services to the Forms were or less than 80% of days. In p.m. HIC stated models the ort was inaccurate weekends and/s days she ion. HIC stated she was having ensuring the postings were	F3	356		

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: WU49

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

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AC	GENCY	F	acility ID: 00940
1. MEDICARE/MEDICAID PROVIDER N (L1) 245310 2.STATE VENDOR OR MEDICAID NO. (L2) 810313500	10.	3. NAME AND AD (L3) BENEDICTI (L4) 1101 BLACK (L5) NEW BRIGH	NE HEALTH CE COAK DRIVE			55112	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP (L34)	7. PROVIDER/SUI 01 Hospital 02 SNF/NF/Dual	<u> </u>	Y 09 ESRD 10 NF	02 (L7		7. On-Site Visit 8. Full Survey After Con	9. Other
8. ACCREDITATION STATUS: 0 Unaccredited	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 09/30	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds	105 (L18) 105 (L17)	B. Not in Com	nce With equirements	1	2. Teck 3. 24 I	hnical Personnel	6. Scope of Servic 7. Medical Direct 8. Patient Room S 9. Beds/Room	or
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 105	19 SNF	ICF	IID		15. FACILITY M		(L15)	
(L37) (L38) 16. STATE SURVEY AGENCY REMARK	(L39) KS (IF APPLICABLE S	(L42) SHOW LTC CANCELL	(L43) LATION DATE):					
17. SURVEYOR SIGNATURE	Jnit Supervis	Date :	05/13/2015	(L19)		evey agency ap	proval prcement Specia	Date:
	PART II - TO	BE COMPLETE	D BY HCFA RI		OFFICE OR	SINGLE STAT	E AGENCY	(L20)
DETERMINATION OF ELIGIBILITY			MPLIANCE WITH C	CIVIL	2.		ial Solvency (HCFA-2572) interest Disclosure Stmt (HCFA	-1513)
22. ORIGINAL DATE OF PARTICIPATION 02/26/1986 (L24)	23. LTC AGREEM BEGINNING (L41)		24. LTC AGREEME ENDING DATI (L25)		26. TERMINA VOLUNTARY 01-Merger, Closs 02-Dissatisfactio	00	INVOLUNT. 05-Fail to Me	eet Health/Safety
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIV A. Suspension B. Rescind Sus	of Admissions:	(L44)		03-Risk of Involu	untary Termination for Withdrawal	OTHER 07-Provider S 00-Active	Status Change
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C	(L45) CARRIER NO.	(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539		. DETERMINATION (OF APPROVAL DA			7/15/2015 Co		
	(L32)			(L33)	DETERMINA	ATION APPRO	VAL	



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:

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

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 /	(Y2) Multiple Construction		(Y3) Date of Revisit
	Identification Number	A. Building		5/13/2015
	245310	B. Wing		5/15/2015
Name	of Facility		Street Address, City, State, Zip Code	
BE	NEDICTINE HEALTH CENTER INNSBRU	JCK	1101 BLACK OAK DRIVE	
BENEBIOTINE HEAETH GENTER INNOBIGO			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
		Correction				Correction					Correction
10 D		Completed	10.0 6			Completed		ID D . "			Completed
ID Prefix	F0225	_05/05/2015	ID Prefix			05/05/2015		ID Prefix	F0282		05/05/2015
-	483.13(c)(1)(ii)-(iii), (c)(2) -			483.13(c)				-	483.20(k)(3)(ii)		_
		-	LSC					LSC			_
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix	F0312	05/05/2015	ID Prefix	F0323		05/05/2015		ID Prefix	F0356		05/05/2015
Reg. #	483.25(a)(3)		Reg. #	483.25(h)					483.30(e)		
LSC		-	LSC					LSC			
		Correction				Correction					Correction
ID Prefix		Completed	ID Prefix			Completed		ID Prefix			Completed
		_				-					_
Reg. #		-	Reg. #					Reg. #			_
		-	Loc				+-				
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix		_	ID Prefix					ID Prefix			_ '
Reg. #			Reg. #					Reg. #			
LSC		- -	LSC					LSC			- -
		Correction				Correction					Correction
ID Prefix		Completed	ID Prefix			Completed		ID Prefix			Completed
Reg. #			Reg. #					Reg. #			_
LSC		-									_
Reviewed By	Reviewed	Ву	Date:	Signature of	Surve	yor:				Date:	
State Agency		S/KJ	05/21/20			2924	9				3/2015
Reviewed By	•	•	Date:	Signature of	Surve					Date:	<u>-, -, -, -, -, -, -, -, -, -, -, -, -, -</u>
CMS RO		-				-					
Followup to	Survey Completed on:			Check fo	or any	Uncorrected I	Deficie	encies. Was	a Summary of		
3/26/2015			Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?					to the Facility?	YES	NO	

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 245310	(Y2) Multiple Constr A. Building B. Wing		N BUILDING 01	(Y3) Date of Revisit 4/24/2015		
Name	of Facility			Street Address, City, State, Zip Code			
BENEDICTINE HEALTH CENTER INNSBR		ICK		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
			Correction Completed					Correction Completed					Correction Completed
ID Prefix			03/30/2015		ID Prefix			03/31/2015		ID Prefix			_03/30/2015
Reg. #	NFPA 101				-	NFPA 101				-	NFPA 101		_
LSC	K0011				LSC	K0029				LSC	K0050		_
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
						-		-					_
Reg. # LSC					Reg. # LSC					Reg. #			_
				1					+-				
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix			•		ID Prefix			_
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			_
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
													_
Reg. # LSC					Reg. # LSC					Reg. #			_
	-			-					<u> </u>				_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			-		ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			_
												1	
Reviewed By	Revie	wed E	Ву	Da	te:	Signature of	f Surve	yor:				Date:	
State Agency	,	PS	S/KJ	5	/21/201	5		1242	24			4/24/	2015
Reviewed By	Revie	wed E	Зу	Da	te:	Signature of	f Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed on	1:				Check	for any	Uncorrected	Defici	encies. Was	a Summary of		
	3/26/2015					Unc	orrecte	d Deficiencies	(CMS	S-2567) Sent	to the Facility?	YES	NO

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 245310	(Y2) Multiple Constru A. Building B. Wing	uction 02 - NEW	BLDG	(Y3) Date of Revisit 4/24/2015		
Name	of Facility			Street Address, City, State, Zip Code			
BENEDICTINE HEALTH CENTER INNSBR		ICK		1101 BLACK OAK DRIVE			
	DENEDICTINE HEAETH GENTER INNODICOR			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) I	Date
ID Prefix			Correction Completed 03/30/2015		ID Prefix			Correction Completed 03/30/2015		ID Prefix			Correction Completed 03/30/2015
Rea.#	NFPA 101					NFPA 101					NFPA 101		
_	K0011				-	K0018				-	K0050		_
				-					+-				
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg.#			-		Reg. #			
LSC					LSC								_
				-					+-				
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg.#			-		Reg. #			
LSC					LSC								_
				-					+-				
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg. #			•		Reg. #			_
LSC					LSC					•			_
	-			-					+-				
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			=		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg. #			•		Reg. #			_
LSC					LSC					LSC			_
				-					-				_
Reviewed By	Revie	ewed B	Ву	Da	te:	Signature of	f Surve	yor:				Date:	
State Agency	,	PS/	′KJ	5/	21/201	5		12424	4			4/2	4/2015
Reviewed By	Revie	ewed E			te:	Signature of	f Surve					Date:	
CMS RO			=					=					
Followup to	Survey Completed o	n:				Charle 4	or on:	Uncorrected	Dofici	oncine Man	a Summary of	1	
	3/26/2015			-			-				to the Facility?	YES	NO
	3/20/2013								*	•		IES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: WU49

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

	PART	I - TO BE COM	PLETED BY 1	THE STAT	E SURVEY	AGENCY	F	acility ID: 00940
1. MEDICARE/MEDICAID PROVIDER N (L1) 245310 2.STATE VENDOR OR MEDICAID NO. (L2) 810313500	io.	3. NAME AND ADI (L3) BENEDICTI (L4) 1101 BLACK (L5) NEW BRIGH	NE HEALTH CI COAK DRIVE			(L6) 55112	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9)		7. PROVIDER/SUF	05 HHA	09 ESRD	02 13 PTIP	(L7) 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other mplaint
6. DATE OF SURVEY 03/26 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIG	CE	FISCAL YEAR ENDING 09/30	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	105 (L18) 105 (L17)	X B. Not in Com	equirements Based On:	m	2. 3. 4.	pproved Waivers Of The Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code B*	Following Requirements: 6. Scope of Servi 7. Medical Direct 8. Patient Room S 9. Beds/Room (L12)	or
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 105 (L37) (L38)	19 SNF (L39)	ICF	IID (L43)		15. FACILIT	Y MEETS 1) or 1861 (j) (1):	(L15)	
	. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):							
17. SURVEYOR SIGNATURE		Date :				SURVEY AGENCY API		Date:
Holly Kranz, I			04/27/2015	(L19)	Kate JohnsTon, Enforcement Specialist 05/20/2015 (L20)			
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Par 2. Facility is not Eligible	7	20. COM	D BY HCFA R IPLIANCE WITH O			Statement of Financi	al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	n-1513)
22. ORIGINAL DATE OF PARTICIPATION 02/26/1986 (L24)	23. LTC AGREEMI BEGINNING (L41)		24. LTC AGREEM ENDING DAT (L25)		VOLUNTAL 01-Merger, 0 02-Dissatisfa	Closure action W/ Reimbursemer	INVOLUNT 05-Fail to Mo	ARY teet Health/Safety eet Agreement
25. LTC EXTENSION DATE: (L27)	A. Suspension of B. Rescind Sus	of Admissions:	(L44) (L45)			nvoluntary Termination ason for Withdrawal	OTHER 07-Provider 00-Active	Status Change
28. TERMINATION DATE:	(L28)	. INTERMEDIARY/C	ARRIER NO.	(L31)	30. REMAR	RKS		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DA	ATE	Posted	05/22/2015 co.		
	(L32)			(L33)	DETERM	IINATION APPRO	VAL	



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:

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

Benedictine Health Center Innsbruck April 8, 2015 Page 2

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.

Benedictine Health Center Innsbruck April 8, 2015 Page 4

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 Benedictine Health Center Innsbruck April 8, 2015 Page 5

> 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

Scansoft /27/ 5

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

PRINTED: 04/08/2015 FORM APPROVED

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		245310	B. WING		00/00/0045
	ROVIDER OR SUPPLIER		STRE 1101	ET ADDRESS, CITY, STATE, ZIP CODE BLACK OAK DRIVE BRIGHTON, MN 55112	03/26/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BR/FD COMPLETION
F 000	INITIAL COMMENTS	3	F 000	APR 2	1 2015
	as your allegation of Department's accept	ance. Your signature at the ge of the CMS-2567 form will			of Health Rourd
Upon receipt of an acceptable POC an revisit of your facility may be conducted validate that substantial compliance with regulations has been attained in accompour verification.		may be conducted to ial compliance with the attained in accordance with			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (d INVESTIGATE/REPO ALLEGATIONS/INDIV	PRT	F 225		
	been found guilty of a mistreating residents had a finding entered registry concerning al of residents or misapp and report any knowle court of law against a indicate unfitness for	employ individuals who have abusing, neglecting, or by a court of law; or have into the State nurse aide cuse, neglect, mistreatment propriation of their property; edge it has of actions by a n employee, which would service as a nurse aide or ne State nurse aide registry s.			
	involving mistreatmer including injuries of ur misappropriation of reimmediately to the ad to other officials in acuthrough established p State survey and cert	nknown source and esident property are reported ministrator of the facility and cordance with State law rocedures (including to the		(appay)	

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPLE	
		245310	B. WING_	,	03/2	6/2015
	ROVIDER OR SUPPLIER	NNSBRUCK		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	violations are thoroug prevent further potent investigation is in product to the administrator or representative and to with State law (includicertification agency) vincident, and if the all appropriate corrective This REQUIREMENT by: Based on interview a facility failed to ensure were immediately rep	thly investigated, and must tial abuse while the gress. stigations must be reported r his designated other officials in accordance ing to the State survey and within 5 working days of the eged violation is verified e action must be taken. is not met as evidenced and document review, the e all allegations of abuse orted to the state agency or for 3 of 8 allegations (R3,	F:	F225 D Facility failed to ensure their abuse prohibition policy w implemented for 3 of 8 allegation abuse reviewed. How will we correct for issue cit No resident was harmed related to citation. There was no suspected abuse/neglect in the 3 cases. All incidents were reported, investigat and cleared by OHFC. What measures or systemic chan 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 issu immediately.	ns of ed? this ted	
	2/23/15, revealed a b status (BIMS) score of impairment), and indicassistance of one to the daily living. A Facility Incident Traindicated on 2/17/14, nurse that nursing assistance by her shoulders of tracking form for the interest of the status of the	am data set (MDS) dated rief interview for mental of 10 (moderate cognitive cated R3 required extensive wo staff for all activities of acking Report dated 2/24/15, R3 had reported to a charge sistant (NA)-B had shaken during care. An initial incident revealed the as reported to the SA the		How will we monitor its performance to make sure that solutions are sustained? We reviall incidents at daily IDT meetings ensure we are compliant. Date when corrective action will completed. May 5, 2015. Director Social Services is responsible.	to .	

FORM APPROVED

PRINTED: 04/08/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 245310 B. WING 03/26/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE BENEDICTINE HEALTH CENTER INNSBRUCK **NEW BRIGHTON, MN 55112** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 2 F 225 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/08/2015 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 245310 B. WING 03/26/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE BENEDICTINE HEALTH CENTER INNSBRUCK NEW BRIGHTON, MN 55112 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 225 Continued From page 3 F 225 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 226 483.13(c) DEVELOP/IMPLMENT F 226 ABUSE/NEGLECT, ETC POLICIES SS=D 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:

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

	CO TOTAL CO	MEDIO/ NO OLIVVIOLO				NIND MC	J. U936-U391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI			(X3) DATE	
		245310	B. WING			03/	26/2015
NAME OF P	ROVIDER OR SUPPLIER	·		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	TINE HEALTH CENTER!	NNSBRUCK		110	01 BLACK OAK DRIVE		
				NE	EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	E	(X5) COMPLETION DATE
F 226	Continued From page	. 4	-	226			
		nd document review, the	"	220	F226 D Facility Call 1	•	
	facility failed to impler	nent their abuse reporting			F226 D Facility failed to ensure	:	
	procedure related to i	mmediate reporting of			allegations of abuse were report immediately to the state agency	ted	
	allegations of abuse to	o the state agency (SA) and 8 allegations (R3, R102,			3 of 8 allegations reviewed.	ior	
	R200) reviewed.	o anogations (10, 11102,			Have will		
					How will we correct for issue cit	ted?	
	Findings include:				No resident was harmed related to	this	
					citation. There was no suspected abuse/neglect. All incidents were		
	R3's quarterly minimu	m data set (MDS) dated			reported, investigated and cleared	1	I
	2/23/15, revealed a bi	ief interview for mental		1	OHFC.	ру	
	status (BIMS) score o	f 10 (moderate cognitive			5111 6.		
		cated R3 required extensive			What measures on greatening		
	daily living.	wo staff for all activities of			What measures or systemic char	nges	I
	daily fiving.				will be made to ensure that the		
	A Facility Incident Trad	cking Report dated 2/24/15,			deficient practice will not recur?		
		R3 had reported to a charge			We will create and use a form that		
		sistant (NA)-B had shaken			captures the timeline of all reportal	ble	
	her by her shoulders of	luring care. An initial		ļ	incidents and use that form to mon	itor	1
`	tracking form for the ir		1		report times to ensure that all		
		as reported to the SA the			reportable incidents are reported		l
	next day, 2/18/15.	•			immediately and within the time fra	ame	1
	D100la augustantu MD0	datad OMOME was a last		į.	identified by law.		
	R102 S quarterly MDS	dated 2/16/15, revealed 3 (cognitively intact), and					
	indicated R102 had no	o history of hallucinations.			How will we monitor its	1	
	maiodica i (102 ilau il	Thistory of Halluchtauoris.				.	
	A facility Incident Repo	ort Submission indicated on			performance to make sure that		
ļ		d an unidentified nurse of			solutions are sustained? We revie		
1	kneeling on her feedin	g tube site during cares.			all incidents at daily IDT meetings a		
, 1	The report was not sul	omitted to the SA until			weekend/evening supervisors review	w	
	1/30/15, two days afte	r the allegation was initially			to ensure we are compliant.	-	1
		ker (SW)-A from a physical			-		
ĺ	therapy staff member	via email.			Date when corrective action will b	ne	Ì
	P200's guartaria MADO	dated 19/5/14 A warrantant			completed. May 5, 2015. Director		1
	R200's quarterly MDS	dated 12/5/14, revealed			Social Services is responsible	01	l

cognitive impairment) and no behavioral

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245310	B. WING_			03/26/2015		
	ROVIDER OR SUPPLIER TINE HEALTH CENTE	R INNSBRUCK		STREET ADDRESS, CITY, STATE, 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		00/20/2010		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE		
F 226	R200 had been four facility parking lot of he was going to che was not sure day on 9/8/14. During interview or director of social set of abuse should be facility staff needed [reporting immediate nursing staff general abuse to the DON, administrator. The until next day to represident was safe aduring the night, an notified immediately via text or email, ar were put on suspers the incident. During interview on director of nursing (an allegation of abuad ministrator immediately to 24 hours to restricted to the SA, I he DON sincident involving Rafter it had happened administrator and Sof the incident.	g submitted to the SA indicated and wandering toward the on 9/7/14, and R200 had stated eck out the patio by the lent tracking indicated the abmitted to the SA until the next of 3/26/15, at 11:29 a.m. the ervices (DSS) stated incidents are ported immediately, and it o "Get sharper on that tely]." The DSS stated the ally reported allegations of who immediately notified the DSS stated she might wait bort an incident to the SA if the and something happened and the administrator was by at time of the verbal report and any alleged perpetrators are incident to the SA if the following investigation of a 3/26/15, at 1:36 p.m. the grow and then report the diately and then report the however, she stated she had aport allegations of abuse to stated she was unaware of the 102 until a couple of days ed, and had notified the A when she was made aware	F 2	226				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATI	(X3) DATE SURVEY COMPLETED	
		245310	B. WING			03	3/26/2015	
	ROVIDER OR SUPPLIER TINE HEALTH CENTER II	NNSBRUCK		1	STREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE IEW BRIGHTON, MN 55112			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 226	facility administrator s immediately of allegat she thought the facility report incidents to the abuse or neglect was initial report. The facility policy titled dated 1/15, instructed should be immediately		F	226				
	must be provided by q accordance with each care. This REQUIREMENT by: Based on observation review the facility failed (R95) reviewed for actireceived assistance withe care plan. Findings include: R95's quarterly minimumumumumumumumumumumumumumumumumumu	or arranged by the facility ualified persons in resident's written plan of is not met as evidenced, interview, and document to ensure 1 of 1 resident vities of daily living the shaving as directed by and data set (MDS) dated had moderate cognitive ed extensive assistance of a activities.	F:	282	F 282 D Facility failed to ensure 2 residents reviewed for activitie daily living received assistance was grooming as directed by the carplan. The resident in question requires assistance with all activities of dailiving, but often declines assistance from staff and sometimes gets agin when staff attempt to redirect resident. The resident has a new shaver (previous shaver was broken became takes it apart). Staff have been to help him shave almost daily. If refuses, this is documented in EHI eMAR.	es of with e		
	9/23/14, indicated R95	needed assistance in all including grooming due to		.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245310	B. WING			03	/26/2015
	ROVIDER OR SUPPLIER	NNSBRUCK		110	REET ADDRESS, CITY, STATE, ZIP CODE 1 BLACK OAK DRIVE W BRIGHTON, MN 55112	1 00	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 282	muscle weakness. R95's care plan dated diagnoses including tr difficulty walking, and with shaving daily. During observation or had a significant amounder his chin and on interview at this time, be clean shaven but in shave. During observation on was still unshaven. R95"Forever," to come to staff had still not helpe wish they would." During observation on was observed with sigupper neck and chin a long. Nursing Assistanis morning cares and assistance before leaversidents. During interview on 3/2 stated he wished staff consistently, and he were trimmed. During interview on 3/2 stated R95 should be shaving on a daily bassing and with sigupser neck and chin a long. Nursing Assistants his morning cares and assistance before leaversidents.	a 3/25/15, indicated R95 had remor, muscular atrophy, required staff assistance a 3/23/15, at 7:40 p.m. R95 and of facial hair, especially the upper neck. During R95 stated he preferred to needed staff to help him a 3/24/15, at 9:17 a.m. R95 as stated it took them [staff] help him this morning and and him to shave but, "I sure a 3/25/15, at 8:45 a.m. R95 anificant facial hair on the area, approximately 3/4" and (NA)-A assisted R95 with a did not offer R95 shaving ving the room to assist other 25/15, at 9:47 a.m. R95 awould shave him	F	282	What measures or systemic chawill be made to ensure that the deficient practice will not recurresidents are asked on admission quarterly how often they want to shaved and this recorded on the sintegrity form and care plan. All patient and resident ADLs are assessed upon admission to the facility, quarterly, annually and wignificant change. ADLs provide 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 chanceds and follow-up is completed needed. Date when corrective action will completed. April 22, 2015. The Director of Nursing or designee is responsible.	? All and be kin with ed by ty .	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) I IDENTIFICATION NUMBER: A. BL			CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		245310	B. WING			0	3/26/2015	
BENEDIC	PROVIDER OR SUPPLIER TINE HEALTH CENTER I	NNSBRUCK		110	REET ADDRESS, CITY, STATE, ZIP CODE 01 BLACK OAK DRIVE EW BRIGHTON, MN 55112		0.20.2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 282	During interview on 3/ registered nurse (RN) director of nursing, sta shaving assistance da available for use.		F2	282			-	
SS=D	were requested, but n 483.25(a)(3) ADL CAF DEPENDENT RESIDE A resident who is unat daily living receives th maintain good nutritior and oral hygiene. This REQUIREMENT by: Based on observation review the facility failed (R95) reviewed for act received assistance wi Findings include: R95's quarterly minimu 3/21/15, indicated R95 impairment, and requir one staff for all groomir R95's care area assess 9/23/14, indicated R95 activities of daily living muscle weakness.	ot provided. RE PROVIDED FOR ENTS ble to carry out activities of enecessary services to a, grooming, and personal is not met as evidenced interview, and document to ensure 1 of 1 resident vities of daily living the shaving. In data set (MDS) dated had moderate cognitive ed extensive assistance of any activities. In activities. In activities of dated eneeded assistance in all including grooming due to	F3	312	F312 D Facility failed to ensure 2 residents reviewed for activitic daily living received assistance v shaving. The resident in question requires assistance with all activition of daily living, but often declined assistance from staff and sometime gets agitated when staff attempt to redirect resident. Staff will continuoffer to shave resident daily as he allows and document in the facility electronic medical record. How will we correct for issue cite Staff will offer to shave resident eviday and as needed. This information has been place on the resident plan care to reflect resident daily care needs.	es of vith es es eto d? ery n		
1	R95's care plan dated 3	3/25/15, indicated R95 had				•		

CLIVILLI	S FOR WEDICARE &	MEDICAID SEKVICES			OIVID IV	O. 0530-0351	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245310	B. WING		0:	3/26/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
·				1101 BLACK OAK DRIVE			
BENEDIC	TINE HEALTH CENTER I	NNSBRUCK		NEW BRIGHTON, MN 55112			
	0.1444514.57			- 		Т	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 312	Continued From page	. 0	F 24				
1 312			F 31	2			
		remor, muscular atrophy,		****	.h.a.a.a		
		I required staff assistance		What measures or systemic of			
	with shaving daily.			will be made to ensure that t		,	
	During observation of	n 3/23/15, at 7:40 p.m. R95		deficient practice will not rec			
	1 -	ount of facial hair, especially		All patients and residents will	be		
		the upper neck. During		asked about their shaving prefe	erences		
		R95 stated he preferred to		on admission by the admitting			
		needed staff to help him		and this information will be			
	shave.	•		documented on the admission	ekin		
			-				
	During observation or	n 3/24/15, at 9:17 a.m. R95		integrity form. This information			
-		95 stated it took them [staff]		then be incorporated into the p		,	
		help him this morning and		plan of care. Daily rounds ide	-		
		ed him to shave but, "I sure		any resident needs and follow-	up is		
	wish they would."			completed as needed.			
	During observation or	n 3/25/15, at 8:45 a.m. R95					
	l '	gnificant facial hair on the		How will we monitor its			
		area, approximately 3/4"		performance to make sure th	ıat		
•		ant (NA)-A assisted R95 with		solutions are sustained? The	:		
		d did not offer R95 shaving		information will be reviewed			
	l .	ving the room to assist other		quarterly, annually and with			
	residents.			significant change.			
	During interview on 3	/25/15, at 9:47 a.m. R95		organization organization			
	stated he wished staf			Determine accurative action	will be		
	consistently, and he			Date when corrective action			
	trimmed.		_	completed. April 22, 2015.			
-				Director of Nursing/designee i	.S		
	During interview on 3	/25/15, at 9:48 a.m. NA-A		responsible.			
		offered assistance with					
		sis, and his electric razor					
	1	eeded to use a straight					
	razor to shave R95.			•			
	D	10545					
	During interview on 3				•		
•])-C, who was the assistant					
	unector or nursing, st	ated R95 should be offered	1			1 1	

1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
245310	B. WING		03/26/2015	
SBRUCK		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
UST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION	
o shaving and grooming provided. CIDENT ON/DEVICES that the resident of free of accident hazards or resident receives and assistance devices to a not met as evidenced interview, and document to ensure bed side rails Food and Drug quirements to minimize for 1 of 1 resident (R291) fety. In Data Set (MDS) dated had moderately impaired extensive assistance for ving (ADLs), including bed 3/20/15, indicated the vo, one on each side of		F323 D Facility failed to ensure I 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 cite. The bed in question was exchanged immediately on March 24. A new was purchased and is in use. What measures or systemic changed immediately on the systemic changed in the systemi	d? loed ges for so ace e to	
	IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER: 245310 B. WING	245310 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112 D. PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRE DEFICIENCY) D. A and R95 had razors TAG F 312 F 323 F 323 F 323 D Facility failed to ensure the risk of entrapment to minimize the risk of entrapment, for 1 of 1 resident receives and assistance devices to The dimension was exchanged immediately on March 24. A new was purchased and is in use. What measures or systemic change 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 safety and passed, it is remotely possible for the knob to come loose we got rid of them. All beds are already on a preventative maintenar monthly check and we will continue do this. All residents, including the individual in this bed, are assessed to use side rails safely.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		INSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245310	B. WING_			03	3/26/2015
	ROVIDER OR SUPPLIER TINE HEALTH CENTER	INNSBRUCK	·	1101	ET ADDRESS, CITY, STATE, ZIP CODE BLACK OAK DRIVE / BRIGHTON, MN 55112	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page assist R291 with be	ge 11 d mobility and positioning.	FS	323			
	including chronic ob (COPD), generalize status post rehabilitiassessment identificatione-half side rails to from COPD, and for with bed mobility an assessment lacked were evaluated to brisk for entrapment. During observtion or bilateral, half, metal R291's bed, with the against the wall. The observed tilted down 30 degrees from the the bed. The rail also from the bed, at an adegrees from the top the rail. The spacing the rail to the mattre (FDA zone six), was half inches. Upon mand maneuverable, and perpendicular to even greater spacing the room at the time. During interview on a director of nursing (Enables of pears and years." The spacing the room at the time.	ation procedure. The ed R291 required two, whis bed, related to weakness increased independence d/or transfers. The eany indication the side rails e safe for R291, to reduce the end 3/23/15, at 1:05 p.m. side rails were raised on a far side of the bed flush e outward-facing side rail was a at an angle of approximately head of the bed to the foot of angled outward, lying away angle of approximately 15 of the rail to the bottom of between the under-side of sa at the head of the bed greater than seven and one anipulation, the rail was loose with movement both parallel of the mattress, allowing for grat zone six. R291 was not in			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 resider side rail assessments. Date when corrective action will completed. April 3, 2015. Director of Environmental Services is responsible.	nt be or	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	, and the second se		X3) DATE SURVEY COMPLETED	
		245310	B. WING			03/	26/2015	
	ROVIDER OR SUPPLIER	INNSBRUCK	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		DDE		20/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
	not be tightened and bedframe as the hard attempting to tighten the rail remained loo spacing in zone six chalf inches, which puentrapment. On 3/24/15, at 9:35 a was very loose and hand felt they were, "It to pull on that thing Is maneuvered the side perpendicular to the you think it's going to During interview on 3 DON, facility adminis services director (ES stated the side rails of The DON, facility adminis services director (ES stated the side rails of The DON, facility adminis services director (ES stated the side rails of they were familiar with side rail safety spacing entrapment, and the the facility beds and sand checked routinel turned the black knot while she set the rail no longer tilted outwatighten the black knot the bed frame, limiting rail and setting the rail in acceptable spacing. Review of the facility's safety audits indicate	bed frame, that the rail could it was as secured to the dware allowed. After the rail, the DON confirmed se and maneuverable, with if greater than seven and one it R291 at risk for a.m. R291 stated his siderail le did not utilize the side rail Jseless." R291 stated, "Try siderail]." As writer a rail, both parallel and bed, R291 stated, "Exactly, hold 200 pounds?" 5/24/15, at 10:07 a.m. the trator and the environmental D) were interviewed and all on R291's bed were loose. In inistrator, and ESD stated the FDA requirements for bed and the properties of the right on the side rail, parallel to the bed so it was lard, and she was able to be, securing the rail firmly to go the maneuverability of the ill in a manner which resulted to for zone six.	F	323				
	was last inspected or	2/25/15, prior to R291's ity. The audit did not specify						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		245310	B. WING _		03/26/2015
	ROVIDER OR SUPPLIER TINE HEALTH CENTER I	NNSBRUCK		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	•
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	D BE COMPLETION
F 323	just indicated, "Everythe The facility's Adaptive 1/15, indicated, "The space between all mareduce the risk for entities and mattress being beds and mattresses purchased and installichecked annually, quachange and PRN [as to the adaptive equipmed Hospital Bed System Assessment Guidance dated 3/10/06, detailed rail safety. The guide openings in the bed stand four and three-quirisk of head entrapmed defined zone six as the	il which were examined and thing checked out." E Equipment policy dated facility has assessed the attress and side rails to trapment (the amount of depending on the type of are assessed if they are ed Residents are arterly, with significant needed] for safety relative ment used." Dimensional and e to Reduce Entrapment, and the FDA guidance on side	F 3:	23	
F 356 SS=C	483.30(e) POSTED N INFORMATION The facility must post a daily basis: o Facility name. o The current date. o The total number and by the following categoralicensed nursing started nursed nursed nursed nursed nursed nursed Registered nursed nursed nursed nursed practical	the following information on If the actual hours worked ories of licensed and aff directly responsible for	F 38	56	

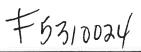
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245310	B. WING		03/26/2015
	ROVIDER OR SUPPLIER TINE HEALTH CENTER	NNSBRUCK		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION
F 356	- Certified nurse a o Resident census. The facility must post specified above on a of each shift. Data mo Clear and readable o In a prominent place residents and visitors. The facility must, upon make nurse staffing of the facility must main staffing data for a mineral content.	the nurse staffing data daily basis at the beginning ust be posted as follows: format.	F 356	F356 C Facility failed to consistently include the currer census information on the numbours posting. How will we correct for issue We posted the correct form that been delayed in posting on 2 of bulletin board postings. What measures or systemic che will be made to ensure that the deficient practice will not recu We will post on the Garden Tembulletin board near the lobby are We will post a reference on each the other 3 bulletin boards to dir visitors to correct posting location.	cited? chad the 4 nanges e ur? race ea. n of
	by: Based on observation review, the facility fail current census inform hours posting. This had 100 residents who residents who residents who residents who residents who residents who residents include: During initial tour of the 12:59 p.m. the facility Form dated 3/23/15, bulletin boards at the Transitional Care Unit Village Unit. The sect designated for notation	ne facility on 3/23/15, at a second service Hours was observed affixed to the entrances of both the act (TCU) and the Pioneer ions of each form of the census during each and the facility census was		We will ensure that the census is on the posting. How will we monitor its performance to make sure that solutions are sustained? The street coordinator will check status dait On the weekends and holidays, the nursing supervisor will add census Sheets will be audited once per what by the staffing coordinator. Date when corrective action with completed. April 1, 2015. Directly of Nursing is responsible.	t taffing ly. he us. week

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245310	B. WING			03	/26/2015
	ROVIDER OR SUPPLIER	NNSBRUCK		1101	EET ADDRESS, CITY, STATE, ZIP CODE 1 BLACK OAK DRIVE N BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 356	During interview on 3, information coordinate main employee responsible of the facility's Nursing stated on weekdays wa.m., she looked up the electronic medical reconstruction with the overnight character with the end of the charges shift, and made the appearance of their shift. On which was responsible schedule changes and end of their shift. On which will be compacted information to the facility census was posting for eight out of 80 days, of the facility's Nursing States of the every compact of t	/24/15, at 3:11 p.m. health or (HIC) stated she was the nsible for daily completion g Service Hours Form. HIC when she arrived at 6:45 he census in the facility's cord system and checked arge nurse to determine my updates to the scheduled and then completed the formation and posted them in each unit of the facility. of her shift she again here were updates to the led hours for the afternoon propriate adjustments to be left the facility each day. In ourse from the evening for identifying census or district updating the forms at the evekends, the charge were responsible for the current census and for the subsequent shift. In our Hours Forms from 5, indicated the following: Is not identified on the factor of the subsequent shift, which is not added to the posting tening shift, for an additional or 10% of days. Service Hours Forms were ess than 80% of days. M. HIC stated most of the	F	356	DEFICIENCY)		
	days where the report corresponded with we	was inaccurate, ekends and/or days she					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT (AND PLAN OF	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245310	B. WING			03	/26/2015
	ROVIDER OR SUPPLIER TINE HEALTH CENTER I			110	REET ADDRESS, CITY, STATE, ZIP CODE D1 BLACK OAK DRIVE EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
F 356	was gone on vacation	n. HIC stated she was having nsuring the postings were	F:	356			
				-			



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

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING . MAIN BUILDING 01 245310 03/26/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE BENEDICTINE HEALTH CENTER INNSBRUCK **NEW BRIGHTON, MN 55112** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 **INITIAL COMMENTS** K 000 Pocon VIII 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 APR 1 6 2015 DEFICIENCIES (K-TAGS) TO: **HEALTHCARE FIRE INSPECTIONS** MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:

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.

Susu

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

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

Event ID: WU4921

Facility ID: 00940

TITLE

If continuation sheet Page 1 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING • MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245310	B. WING			03/	26/2015
	ROVIDER OR SUPPLIER	NNSBRUCK		11	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE IEW BRIGHTON, MN 55112		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 000	Angela. Kappenman@Marian. Whitney@sta THE PLAN OF CORE DEFICIENCY MUST FOLLOWING INFOR 1. A description of who correct the deficier 2. The actual, or proposed in the proposition of the correct and are constructed in 19 and the constructed in 19 and the constructed in 19 and the construction. This facility was survey buildings because of construction. Buildings to March 1, 2003. The accordance with LSC building was surveye Chapter 18.	gstate.mn.usand te.mn.us RECTION FOR EACH INCLUDE ALL OF THE MATION: nat has been, or will be, done ncy. cosed, completion date. itle of the person ction and monitoring to ce of the deficiency. senter at Innsbruck is a no basement. The building titmes. The original building est times. The original building st times. The original building est and was determined to construction. In 1991 an cted to the north and was Type I(222) construction. In Care Unit (TCU) was added determined to be of Type	K	000	DEFICIENCY		
	sprinkler system. The system that consists	a complete automatic fire e facility has a fire alarm of smoke detection in the					

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BLDG		(X3) DATE COMP	SURVEY LETED	
	245310		B, WING_			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			DAI.	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(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.		K	00				
K 011 SS≃F	NOT MET as evidence NFPA 101 LIFE SAF If the building has a connect nonconforming building barrier having at least rating constructed of addition. Communic corridors and are pro-	ETY CODE STANDARD common wall with a ing, the common wall is a fire st a two-hour fire resistance materials as required for the ating openings occur only in	K	211	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 feet around to pull door	d.	ŭ.	
	Based on observation has failed to maintain the required location could affect the safet visitors in the event could pass from one	not met as evidenced by: on and interview, the facility on the 2-hour fire separation at on. This deficient practice by of all residents, staff and of a fire, as fire and smoke building to the other.			fast enough to pull door shut. Doors were adjusted the actual or proposed dudate. 3/30/15. The name and/or title of the person responsible for	e he		
	03-26-2015, it was o	een 9:30 AM and 2:30 PM on bserved that the 2-hour fire not operate as required in :			correction and monitoring to prevent a reoccurrence the deficiency. Director of Environmental Services	of		

Facility ID: 00940

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
	245310	B. WING	B. WING			26/2015
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK				LACK OAK DRIVE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)						(X5) COMPLETION DATE
each resident room the department notification of 105 census at the state of 105 census at the supply and remeets the CMS S&C-2006. The requirement at 42 NOT MET as evidence NFPA 101 LIFE SAFE of 105 census at the series of 105 census at the state of 105 census a	nat is monitored for fire in. the facility has a capacity ime of this survey was 99 Itten in past surveys. upon igation it has been found eturn for the 1965 building 06-18, letter from May 26, I CFR Subpart 483.70(a) is sed by: ETY CODE STANDARD COMMON Wall with a ng, the common wall is a fire that a two-hour fire resistance materials as required for the ating openings occur only in sected by approved 19.1.1.4.1, 19.1.1.4.2 Into the met as evidenced by: In and interview, the facility I the 2-hour fire separation at I This deficient practice of all residents, staff and if a fire, as fire and smoke building to the other.			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 the deficiency. Director of	e ne of	
· ·				Environmental Services		
	Continued From page each resident room the department notification of 105 census at the form that the supply and meets the CMS S&C-2006. The requirement at 4: NOT MET as evidence NFPA 101 LIFE SAFE If the building has a cononconforming building barrier having at least rating constructed of addition. Communication could affect the safety visitors in the event of could pass from one If Findings include: On facility tour between 03-26-2015, it was obtaited.	CONTINUE HEALTH CENTER INNSBRUCK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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: 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.	CORRECTION DENTIFICATION NUMBER: 245310 B. WING_ ROMDER OR SUPPLIER INE HEALTH CENTER INNSBRUCK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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: 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	CONTINUED TO THE PROPERTY OF DESTRIPTION NUMBER: 245310 245310 245310 245310 245310 245310 245310 25TREE TINE HEALTH CENTER INNSBRUCK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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: 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	ROMDER OR SUPPLIER TINE HEALTH CENTER INNSBRUCK SUMMARY STATEMENT OF DETICIONCIES (EACH DEPICIENCY MAST BE PRECEDED BY FULL REGULATORY OR I.SO IDENTIFYING INFORMATION) 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 1985 building meets the CMS S&C- 08-18, letter from May 26, 2006. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by: 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 oould 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 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 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 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	TINE HEALTH CENTER INNSBRUCK SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY WIST BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 Continued From page 2 A K-037 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: SNOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall with a protected 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 falled 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 lire, 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 03-28-2015, it was observed that the 2-hour fire PREFIX TADDRESS, CITY, STATE, 2IP CODE 1101 BLACK OAK DRIVE TATE, 2IP CODE 110

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 A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
	245310 B. WING			03/	26/2015		
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK				11	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			(X5) COMPLETION DATE
K 011			K	029	K-029 D Soiled Linen Roc 213 door to corridor did r automatically close and latch when tested. A description of what has been done. Hinges adjus so door latches on 3/26/1 Maintenance went on tou throughout the building a checked all doors for latch in the facility that are on closers. Put door latching preventive maintenance li for monthly checks. The actual or proposed de date: 3/31/15 The name and/or title of person responsible for correction and monitoring	ted 5. on ist	
э	on 03/26/2015, it was	en 09:30 AM and 02:30 PM observed that the corridor Linen Room 213 did not d latch when tested.			to prevent a reoccurrence the deficiency. Director of Environmental Services	- 1	

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			E SURVEY IPLETED
245310 NAME OF PROVIDER OR SUPPLIER		B. WING	B. WING			03/26/2015	
	TINE HEALTH CENTER I	NNSBRUCK		1101	EET ADDRESS, CITY, STATE, ZIP CODE Black oak drive / Brighton, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIC DATE
K 029	Continued From page This deficiency was valued Administrator (SA) at	erified by the facility	K	029			
	Fire drills are held at a varying conditions, at The staff is familiar withat drills are part of e Responsibility for plan assigned only to compute qualified to exercise le conducted between 9 announcement may be alarms. 19.7.1.2 This STANDARD is n Based on review of reinterview, it was deter to conduct fire drills in LSC (00) Section 19.7 could affect how staff in Findings include: On facility tour between 0.3/26/2015, based documentation it was retained.	unexpected times under least quarterly on each shift. th procedures and is aware stablished routine. In an an an are seadership. Where drills are PM and 6 AM a coded e used instead of audible of met as evidenced by: Sports, records and mined that the facility failed accordance with NFPA 101 acco	K	050	K-050 C Evening shift find rills 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 contain to do this annually. The actual or proposed date. 3/30/15 The name and/or title or person responsible for correction and monitorist to prevent a reoccurrence the deficiency. Director Environmental Services	he is ies inue f the ng ce of	~

F5310024

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 A. BUILDING	CONSTRUCTION NEW BLDG	COMPLETED	
		245310	B. WING		03/26/2015	
	ROVIDER OR SUPPLIER	INNSBRUCK	11	REET ADDRESS, CITY, STATE, ZIP CODE 01 BLACK OAK DRIVE EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			MARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD PREFIX (EACH CORRECTIVE ACTION SHOULD PREFIX)		
K 000	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		K 000	POCK TITLE	(X6) DATE	
LABORATORY	DIRECTOR & OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATU),,	Ndministration	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.

Event ID: WU4921

Facility ID: 00940

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL [*] A. BUILDI		(X3) DATE SURVEY COMPLETED			
245310			B. WING			03/2	6/2015
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK				1	STREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	4	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Angela.Kappenman@Marian.Whitney@sta THE PLAN OF COR! DEFICIENCY MUST FOLLOWING INFOR 1. A description of wito correct the deficient 2. The actual, or properties of the deficient of the deficient of the prevent a reoccurrent of the deficient of the prevent a reoccurrent of the deficient of the	Estate.mn.usand Ite.mn.us RECTION FOR EACH INCLUDE ALL OF THE RMATION: In that has been, or will be, done Incy. Incosed, completion date. Ititle of the person Iction and monitoring to Ince of the deficiency. Center at Innsbruck is a Inno basement. The building Int times. The original buildin	K	000			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938								
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			W	(X2) MULTIPLE CONSTRUCTION A, BUILDING 02 - NEW BLDG			SURVEY ETED	
245310			B. WING			03/2	6/2015	
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK				11	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE EW BRIGHTON, MN 55112			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)			(X5) COMPLETION DATE	
K 011 K 018 SS=D	1) The fire barrier do existing nursing homowhen tested. This deficiency was Administrator (SA) at NFPA 101 LIFE SAFI	or between the new and e did not self close and latch verified by the facility the time of discovery. ETY CODE STANDARD ridor openings are		011	¥:			
ц И	Doors are provided whardware. Dutch doo permitted. Roller late 18.3.6.3 This STANDARD is Based on observation did not have corridor	ors meeting 18.3.6.3.6 are ches are prohibited. not met as evidenced by: on and interview, the facility		i.a	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 an realigned both doors for latching.		€E to	
K 050	19.3.6.3.2. This defic safety of the resident compartment. Findings include: On facility tour between 03/26/2015, it was doors do not properly from the corridor in the corri	een 09:30 AM and 02:30 PM sobserved that the corridor y latch to protect the room he following locations:		⟨ 050	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	e		
K 050	INFEA TOT LIFE SAF	ETT GODE STANDARD	1	. 000				

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

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING 02 - NEW BLDG 245310 03/26/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE BENEDICTINE HEALTH CENTER INNSBRUCK **NEW BRIGHTON, MN 55112** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 050 Continued From page 4 K 050 K-050 C Evening shift fire SS=C drills were not varied Fire drills are held at unexpected times under throughout the shift in the varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware last 12 months. that drills are part of established routine. Responsibility for planning and conducting drills is A description of what has assigned only to competent persons who are been done. All fire drills qualified to exercise leadership. Where drllls are conducted between 9 PM and 6 AM a coded scheduled on Outlook announcement may be used instead of audible through 2015 so that times alarms. 18.7.1.2 are spaced according to regulation. We will continue to do this annually. This STANDARD is not met as evidenced by: Based on review of reports, records and The actual or proposed due interview,, it was determined that the facility failed to conduct fire drills in accordance with NFPA 101 date. 3/30/15 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. The name and/or title of the Findings include: person responsible for correction and monitoring On facility tour between 09:30 AM and 02:30 PM on 03/26/2015, based on review of available to prevent a reoccurrence of documentation it was reveled that Fire drills were the deficiency. Director of not varied throughout the shift on the Evening **Environmental Services** 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.