DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 6, 2020

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

RE: CCN: 245310
Cycle Start Date: September 23, 2020

Dear Administrator:

On November 5, 2020, the Minnesota Department(s) of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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Electronically delivered
October 6, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: 9V6411

Dear Administrator:

The above facility was surveyed on September 22, 2020 through September 23, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susanne Reuss, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Office: (651) 201-3793

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

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING _____ B. WING _____	C 09/23/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/22/20 and 9/23/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5310091C, with a deficiency cited at F561, F585, and F697. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and	F 561		11/2/20

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

Electronically Signed | 10/15/2020

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

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F 561	Continued From page 1 waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on Observation, document review and interview, the facility failed to accommodate bathing choices for 1 of 3 residents (R1) reviewed for choices. Findings include: R1's annual Minimum Data Set (MDS) dated 8/31/20, indicated R1 was cognitively intact, with diagnoses which included chronic pain syndrome and right and left above the knee amputations. R1's Functional Status assessment,t from the annual MDS dated 8/31/20, indicated physical assist of two with bathing. A complaint filed 9/15/20, with the state agency (SA) indicated R1 continued to have concerns	F 561	This plan of correction is submitted as required under Federal and State regulation applicable to long term care providers. This Plan of Correction does not constitute an agreement of findings. 1)How will we correct for individual patient cited? -Resident is currently hospitalized, upon return, R1 will have a care conference to discuss preferences and choices related to but not limited to activities, scheduling of cares, bathing, etc. These preferences will be reflected in the resident's plan of care. 2)How will we identify other residents who have the potential to be impacted by this same deficient practice?	

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F 561	Continued From page 2 about showering weekly and bedding not being changed once a week. During observation, and when interviewed on 9/22/20, at 1:00 p.m. R1 stated, " I have Intravenous Immunoglobulin Therapy (IVIG) every third Friday as outpatient. I don't want to take a shower the Monday after I get IVIG. I feel groggy from the IVIG treatment and feel unsafe in the shower. There are times I had been sleeping and they did not wake me for a shower. It got late one time and I was told it is too late. I never got a shower that week." When interviewed on 9/23/20, at 11:57 a.m. R1 stated, " I was never offered a bed bath." When interviewed on 9/23/20 at 11:49 a.m. registered nurse (RN-A) stated, " If a resident has a missed shower or bath, staff is to tell nurse the resident did not get shower or bath. The nurse can arrange for another time or the nurse manager is informed and arranges for a shower. They can also try to offer a bed bath if shower is missed. There is an order for skin check on shower day. If one is not given it should be documented and the reason, such as a refusal." When interviewed on 9/22/20 at 3:00 p.m. The director of nursing (DON) indicated that the Point of Care ADL Category Report (MDS 3.0) was the only information available regarding documentation of showers or baths given to R1. Document review of the Point of Care ADL Category Report (MDS 3.0) dated 8/1 through 9/22/20, indicated that showers were documented as given on 7/27, 8/8, 8/24 and 9/4.	F 561	-All residents within the community have their choices and preferences honored. -Clinical team has interviewed all residents related to their current bathing schedule and needs. Team verified current plan in place is satisfactory to each resident. 3)What measures or systematic changes will be made to ensure that the deficient practice will not reoccur? -All associates will be educated on Benedictine New Brighton's policy related to resident choice. -All associates will be educated on Benedictine New Brighton's policy related to residents bathing schedule, process for documenting refusals, and for rescheduling cares that did not occur. -Care conference agenda will be altered to include questions related to choices and preferences, bathing needs being met and honored. 4)How will we monitor performance to make sure the solutions are sustained? -DON/designee will audit 5 residents per week both via interview and documentation check to ensure preferences related to bathing was honored and bathing was completed as appropriate. Results of these audits will be reviewed at monthly Quality Council meetings. Determination regarding continuation/discontinuation will occur at that time. 5)Date the corrective action will be completed? November 2nd, 2020 6)Who will be responsible to ensure these changes are carried out?	

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F 561	Continued From page 3 When interviewed on 9/24/20, at 2:30 p.m. RN-A verified she was not aware of R1 not receiving showers and weekly skin checks on the bath days. RN-A verified she was not able to look up if the weekly bathing and skin checks were performed because staff were not documenting in the computer system if these tasks were completed. RN-A stated, "I am in the process now of training the staff how to document into the computer system if the bath and skin checks were completed so I do not know if [R1] had the weekly bathing." Document review of the policy titled, Policy/Procedure: Shower/ Bath and dated January 2005, revision dated February 2015, read, It is the policy of Benedictine Health Center at Innsbruck to provide a complete bath or shower weekly per resident preference and as allowed by policy. The purpose of this policy is to cleanse each resident, stimulate circulation, observe skin, behavior and general condition, provide for muscular activity, and provide social interaction.	F 561	Ishmael Komara DON or designee	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC	F 585		11/2/20

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F 585	Continued From page 4 facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 585		

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conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the

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F 585	Continued From page 6 result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure voiced grievances of timely positioning care, bedding changes and lack of weekly bathing, were addressed, acted upon and documented accordingly for 1 of 3 residents (R1) reviewed for grievances. Findings include: R1's annual Minimum Data Set (MDS) dated 8/31/20, indicated R1 was cognitively intact, with diagnoses which included chronic pain syndrome and right and left above the knee amputations. R1's Functional Status assessment from the annual MDS dated 8/31/20, indicated physical assist of mechanical device and two staff members for transfers and positioning in the wheel chair. A complaint filed 9/15/20, with the state agency (SA) indicated R1 continued to have concerns with having to wait for positioning and transfers to get up and concerns about showering weekly and bedding not being changed once a week. When interviewed on 9/22/20, at 2:00 p.m. R1 expressed "frustration" and stated, "I don't seem to get anywhere, I have written concerns down and I am told it is not good enough, I have to use dates and times and names before they will investigate my concerns." R1 explained telling many staff her concerns but does not feel there is a resolution to receiving timely help to get up and	F 585	1)How will we correct for individual patient cited? -Resident is currently hospitalized, upon return, Resident will be interviewed by DSS related to all aspects of care provided. Concerns will be documented appropriately and will follow community grievance procedure. 2)How will we identify other residents who have the potential to be impacted by this same deficient practice? -A concern from R1 was identified and documented in a care conference note. All associates will be educated that concerns voiced by residents will follow the grievance procedure. -Care conferences conducted in the last 60 days will be reviewed to ensure any concerns that were voiced have been captured via the grievance protocol and are being follow up on appropriately. 3)What measures or systematic changes will be made to ensure that the deficient practice will not reoccur? -Facility currently has a policy and system in place via care conferences to capture, document and resolve resident concerns. All associates who participate in the care conference process will be educated on policy and expectation. -All associates will be educated in their ability to document resident concerns on behalf of a resident and the expectations related to the grievance process.	

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F 585	Continued From page 7 receive bathing and linen changes. R1 stated, "I have called the receptionist at times to try and get help when my call light is on and no one comes to answer." R1 said has gone to administration with concerns and stated, "I have gone to management and told them my concerns but they are not hearing me." Furthermore, R1 stated, "I feel like they take a chunk out of me, sometimes the staff sound like they are yelling, it is so much trauma with some of the staff, constantly fighting for basic things to be done, like I am such an inconvenience. I feel like I am a five year old and they are not listening to me." R1's care conference notes dated 2/11/20, read, "Resident has concerns about having to wait for transfers to get up. Resident has concerns about bedding being changed, which doesn't happen as often because she prefers to sleep in her chair in her room and often has items on her bed." Notes were written by wellness coordinator (WC-A) When interviewed on 9/24/20, at 12:00 p.m. WC-A verified writing the notes 2/11/20, and indicated registered nurse (RN-A) took care of the bedding linen changes by writing it on the aide assignment sheet. WC-A did not complete a grievance concern form for follow up because she thought the problem had been resolved at that time. WC-A did not know if R1 continued to wait for position changes or if R1 received weekly showers/bathing. When interviewed on 9/21/20, at 9:45 a.m. family (F-A) indicated [R1] had continued to complain that the staff do not come and help [R1] to get up or change position and [R1] has called the main desk to try and get someone to come and help [R1] especially after being incontinent because	F 585	4)How will we monitor performance to make sure the solutions are sustained? -DSS/designee will audit 3 care conferences per week to ensure any concerns that were documented have been entered into the resident concern log. Results of these audits will be reviewed at monthly Quality Council meetings. Determination regarding continuation/discontinuation will occur at this time. 5)Date the corrective action will be completed? November 2nd, 2020 6)Who will be responsible to ensure these changes are carried out? Chris Clow DSS or designee	

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staff do not come to help sometimes for hours. F-A indicated [R1's] room is at the end of the hall and maybe that is why it takes so long to get help. F-A indicated telling the facility multiple times since the 2/11/20 care conference that [R1] needs more help to get up and not have to wait so long. F-A indicated the staff say to [R1] if [R1] expresses a concern to write it down and we will take a look at it tomorrow, but they never follow through. F-A indicated the facility staff have told [R1] to take notes and then they will get back to [R1], but [R1] can barely write with the pain in the hands and the facility should offer to write it down for [R1]. F-A indicated [R1] has said words of disappointing, exhausting, dehumanizing, to not get the care. F-A indicated the facility was made aware of these concerns at the February Care conference and the issues continue to be a concern. The facility has not addressed the concerns. F-A indicated [R1] has reported staff telling [R1] they are not going to change[R1's] bed linen because [R1] has too much personal items on the bed and [R1] needs to move the personal items if [R1] wants the bedding changed.

When interviewed on 9/23/20, at 4:30 p.m. social service (SS-A) verified concerns addressed at the February care conference were not written with a resolution and SS-A thought that the situation was resolved. SS-A verified the facility expectation would have been to document the concern and follow the facility policy to ensure a resolution to the concern. Furthermore, SS-A verified due to various circumstances the only other documented care conference for [R1] was in May and [R1] was not in attendance for that conference due to coronavirus in the facility. The SS-A verified there were no concern grievance forms for [R1] on file since admission a year or so ago.

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F 585	Continued From page 9 When interviewed on 9/24/20, at 2:33 p.m. registered nurse (RN-A) verified no grievance or concern form had been completed for [R1] and stated, "I have been gone now for a month so not aware that [R1] continued to have concerns about the showers, position changes and linen changes." RN-A verified showers were not documented as completed in the computer system, nursing skin audits were also not available as completed weekly in the computer system. RN-A verified she had not heard [R1] being told to clear off her personal items from the bed so staff could make the bed. Furthermore, RN-A verified she was not familiar with the grievance process and was not sure about the policy but would check into the policy and interview [R1] further to hear concerns. Document review of the policy titled, Concerns, Grievances and dated 2017, read, "I. To create an environment where resident and customer concerns are solicited and readily resolved. VII. The community assures that after receiving a concern, there is a prompt response by the associates to acknowledge the receipt of the concern investigate, seek a resolution, and keep the resident appropriately apprised of progress toward resolution. The resident/resident representative has a right to receive written response to their concern or grievance if requested. When a resident, resident representative, visitor or family member voices a concern to a staff member, the staff member completes a concern form and forwards the form to the Social Services department/Grievance Officer/designee in a confidential container. III. a. The staff person responsible investigates, resolves the issue and responds back to the	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING _____ B. WING _____	C 09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 585	Continued From page 10 customer within five business days and documents action. Resident satisfaction with the resolution and handling of the concerns is obtained."	F 585		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on document review and interviews, the facility failed to provide adequate pain management for 1 of 3 residents (R1). Findings include: R1's annual Minimum Data Set (MDS) dated 8/31/20, indicated R1 was cognitively intact, with diagnoses which included chronic pain syndrome and right and left above the knee amputations. A complaint filed 9/15/20, with the state agency (SA) indicated R1 continued to have concerns about administration time of pain medications. The Order Summary Report dated 8/1/20, indicated R1 had a doctor's order for Norco 10-325 milligrams(mg) every four hours for pain. The medication administration records (MAR) for August 2020, indicated the scheduled pain medication(s) were administered : 8/5/20, 8:00 p.m., at 9:56 p.m. ; 8/8/20, 8:00 a.m. at 10:18 a.m.; 8/12/20, 8:00 a.m. at 9:27 a.m.; 8/13/20,the	F 697	1)How will we correct for individual patient cited? -Currently, resident is hospitalized. Upon return resident will receive pain medications per facility policy. 2)How will we identify other residents who have the potential to be impacted by this same deficient practice? -All licensed nurses and TMA□s will be educated related to timeliness of med administration. -Medication administration compliance report will be reviewed by DON weekly. Any trends identifying late medications will be reviewed with clinical manager for appropriate follow up and resolution. 3)What measures or systematic changes will be made to ensure that the deficient practice will not reoccur? -Medication administration compliance report will be reviewed by DON weekly. Any trends identifying late medications will be reviewed with clinical manager for	11/2/20

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F 697	Continued From page 11 4:00 p.m. at 5:03 p.m. and 8:00 a.m. at 10:42 a.m. The Order Summary Report dated 9/1/20, indicated that R1 had a doctor's order for hydrocodone-acetaminophen 10-325 mg every four hours for pain. The MAR for September 2020, indicated the scheduled pain medication was administered on 9/7/20, 8:00 p.m. at 9:16 p.m.; 9/9/20, 8:00 a.m. at 10:16 a.m.; 9/10/20, 8:00 a.m. at 10:46 a.m.; 9/11/20, 8:00 a.m. at 11:09 a.m.; 9/15/20, 8:00 a.m. at 11:08 a.m. and 9/19/20, 8:00 a.m. at 9:26 a.m. During observation and when interviewed on 9/22/20, at 1:00 p.m. R1 stated, "My morning medications are scheduled over a three hour span, but my pain medications should be scheduled the same time daily. My pain meds are two to three hours late often. There have been times, once or twice a week in September that my pain medications have been late. They are waiting to bring in my scheduled and pain medications together." When interviewed on 9/22/20, at 2:55 p.m. R1 stated , "When they don't get my scheduled pain medications for me on time, from 4 a.m. to 11 a.m., my pain is out of control. My pain is 8 or 9 out of 10 in my shoulders plus I have pain in abdomen. It takes a while to get caught up with the pain then." When interviewed on 9/23/20, at 10:49 a.m. registered nurse (RN-A) stated "If a pain medication is scheduled, it should be given within one hour before or one hour after the scheduled time. If it is given late, it should be documented and the reason why it is late. The physician	F 697	appropriate follow up and resolution. 4)How will we monitor performance to make sure the solutions are sustained? -DON/designee will audit 5 residents per week to ensure medications have been administered timely. Results of these audits will be reviewed at monthly Quality Council meetings. Determination regarding continuation/discontinuation will occur at this time. 5)Date the corrective action will be completed? November 2nd 2020 6)Who will be responsible to ensure these changes are carried out? Ishmael Komara DON or designee	

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F 697	Continued From page 12 should be notified if the pain cannot be controlled with a late medication administration." When interviewed on 9/23/20, at 1:50 p.m. RN-B stated "There are usually two nurses working the morning shift. [R1] tends to sleep late and she can call when she wants her medications. When a medication is given late we document things such as resident sleeping in, but I guess potentially it is just documented as given late. I guess it is a part of [R1] routine to have medications late." A facility Medication pass times policy dated 4/6/2014, revised 4/2015, identified to provide guidelines for license associate on when to schedule and administer medications. Medications will be scheduled and administered according to the provider's order and within the facility prescribed time frame unless otherwise medically necessary.	F 697		

Electronically delivered
October 6, 2020

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

RE: CCN: 245310
Cycle Start Date: September 23, 2020

Dear Administrator:

On September 23, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend

to the CMS Region V Office that one or more of the following remedies be imposed:

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Office: (651) 201-3793

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by December 23, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR

Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 23, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On September 22 and 23, 2020, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be Not in compliance with the MN State Licensure.

Complaint H5310091C was found to be SUBSTANTIATED and a licensing order is being

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2 000	Continued From page 1 cited at State Tag 1880. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an	21880		11/2/20

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21880	Continued From page 2 advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure voiced grievances of timely positioning care, bedding changes and lack of weekly bathing, were addressed, acted upon and documented accordingly for 1 of 3 residents (R1) reviewed for grievances. Findings include: R1's annual Minimum Data Set (MDS) dated 8/31/20, indicated R1 was cognitively intact, with diagnoses which included chronic pain syndrome and right and left above the knee amputations. R1's Functional Status assessment from the annual MDS dated 8/31/20, indicated physical assist of mechanical device and two staff members for transfers and positioning in the wheel chair. A complaint filed 9/15/20, with the state agency (SA) indicated R1 continued to have concerns	21880	Corrected	

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21880	Continued From page 3	21880		

with having to wait for positioning and transfers to get up and concerns about showering weekly and bedding not being changed once a week.

When interviewed on 9/22/20, at 2:00 p.m. R1 expressed "frustration" and stated, "I don't seem to get anywhere, I have written concerns down and I am told it is not good enough, I have to use dates and times and names before they will investigate my concerns." R1 explained telling many staff her concerns but does not feel there is a resolution to receiving timely help to get up and receive bathing and linen changes. R1 stated, "I have called the receptionist at times to try and get help when my call light is on and no one comes to answer." R1 said has gone to administration with concerns and stated, "I have gone to management and told them my concerns but they are not hearing me." Furthermore, R1 stated, "I feel like they take a chunk out of me, sometimes the staff sound like they are yelling, it is so much trauma with some of the staff, constantly fighting for basic things to be done, like I am such an inconvenience. I feel like I am a five year old and they are not listening to me."

R1's care conference notes dated 2/11/20, read, "Resident has concerns about having to wait for transfers to get up. Resident has concerns about bedding being changed, which doesn't happen as often because she prefers to sleep in her chair in her room and often has items on her bed." Notes were written by wellness coordinator (WC-A)

When interviewed on 9/24/20, at 12:00 p.m. WC-A verified writing the notes 2/11/20, and indicated registered nurse (RN-A) took care of the bedding linen changes by writing it on the aide assignment sheet. WC-A did not complete a grievance concern form for follow up because

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21880	Continued From page 4	21880		

she thought the problem had been resolved at that time. WC-A did not know if R1 continued to wait for position changes or if R1 received weekly showers/bathing.

When interviewed on 9/21/20, at 9:45 a.m. family (F-A) indicated [R1] had continued to complain that the staff do not come and help [R1] to get up or change position and [R1] has called the main desk to try and get someone to come and help [R1] especially after being incontinent because staff do not come to help sometimes for hours. F-A indicated [R1's] room is at the end of the hall and maybe that is why it takes so long to get help. F-A indicated telling the facility multiple times since the 2/11/20 care conference that [R1] needs more help to get up and not have to wait so long. F-A indicated the staff say to [R1] if [R1] expresses a concern to write it down and we will take a look at it tomorrow, but they never follow through. F-A indicated the facility staff have told [R1] to take notes and then they will get back to [R1], but [R1] can barely write with the pain in the hands and the facility should offer to write it down for [R1]. F-A indicated [R1] has said words of disappointing, exhausting, dehumanizing, to not get the care. F-A indicated the facility was made aware of these concerns at the February Care conference and the issues continue to be a concern. The facility has not addressed the concerns. F-A indicated [R1] has reported staff telling [R1] they are not going to change[R1's] bed linen because [R1] has too much personal items on the bed and [R1] needs to move the personal items if [R1] wants the bedding changed.

When interviewed on 9/23/20, at 4:30 p.m. social service (SS-A) verified concerns addressed at the February care conference were not written with a resolution and SS-A thought that the situation was

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21880	Continued From page 5	21880		

resolved. SS-A verified the facility expectation would have been to document the concern and follow the facility policy to ensure a resolution to the concern. Furthermore, SS-A verified due to various circumstances the only other documented care conference for [R1] was in May and [R1] was not in attendance for that conference due to coronavirus in the facility. The SS-A verified there were no concern grievance forms for [R1] on file since admission a year or so ago.

When interviewed on 9/24/20, at 2:33 p.m. registered nurse (RN-A) verified no grievance or concern form had been completed for [R1] and stated, "I have been gone now for a month so not aware that [R1] continued to have concerns about the showers, position changes and linen changes." RN-A verified showers were not documented as completed in the computer system, nursing skin audits were also not available as completed weekly in the computer system. RN-A verified she had not heard [R1] being told to clear off her personal items from the bed so staff could make the bed. Furthermore, RN-A verified she was not familiar with the grievance process and was not sure about the policy but would check into the policy and interview [R1] further to hear concerns.

Document review of the policy titled, Concerns, Grievances and dated 2017, read, "I. To create an environment where resident and customer concerns are solicited and readily resolved. VII. The community assures that after receiving a concern, there is a prompt response by the associates to acknowledge the receipt of the concern investigate, seek a resolution, and keep the resident appropriately apprised of progress toward resolution. The resident/resident representative has a right to receive written

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 6 response to their concern or grievance if requested. When a resident, resident representative, visitor or family member voices a concern to a staff member, the staff member completes a concern form and forwards the form to the Social Services department/Grievance Officer/designee in a confidential container. III. a. The staff person responsible investigates, resolves the issue and responds back to the customer within five business days and documents action. Resident satisfaction with the resolution and handling of the concerns is obtained." SUGGESTED METHOD OF CORRECTION: The Administrator, or designee, could review applicable policies and procedures, inservice staff on identified needs and requirements, and then audit to ensure compliance with facility' policies regarding concerns and grievances. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245310	BENEDICTINE HLTH CTR INNSBRUCK

Type of Survey (select all that apply):

A	K				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

D	D				

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 30921	09-22-2020	09-23-2020	2.00	0.00	4.50	0.00	0.00	7.00
2. Team Leader 42546	09-22-2020	09-23-2020	1.50	0.00	12.25	0.00	0.00	12.25
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 1.25

Total Clerical/Data Entry Hours..... 2

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... N