Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 30, 2024

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

RE: CCN: 245310
Cycle Start Date: March 11, 2024

Dear Administrator:

On April 26, 2024, the Minnesota Department 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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 30, 2024

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

Re: Reinspection Results
Event ID: U9ZH12

Dear Administrator:

On April 26, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 11, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 18, 2024

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

RE: CCN: 245310
Cycle Start Date: March 11, 2024

Dear Administrator:

On March 11, 2024, a survey was completed at your facility by the Minnesota Department of Health 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 June 11, 2024 (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 September 11, 2024 (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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING _____ B. WING _____	C 03/11/2024

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 3/8/24 and 3/11/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53101592C (MN00099889) H53101647C (MN00099699) H53101593C (MN00100394) H53101591C (MN00100017) H53101609C (MN00098419) Deficiencies were issued at F550, F554, F656, F657, F677, and F755. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		4/17/24

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

Electronically Signed | 03/26/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING _____ B. WING _____	C 03/11/2024

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 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity was maintained for 1 of 3 residents (R2) reviewed for activities of daily living.	F 550	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan	

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 03/11/2024

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 550	Continued From page 2 Findings include: R2's significant change Minimum Data Set (MDS) dated 1/12/24, indicated severe cognitive impairment and R2 required moderate assistance with personal hygiene (helper does less than half the effort). R2's Diagnosis List printed 3/11/24, indicated diagnoses of dementia and muscle weakness. R2's Provider Order dated 1/26/24, directed staff to provide R2 with feeding assistance for meals three times daily. R2's care plan dated 10/10/23, indicated R2 required assistance with grooming and bathing. On 3/8/23 at 1:03 p.m., R2 was observed in his wheelchair in the dining room. R2's clothes were soiled with white substance splattered on his pajama pants, and food stains on his shirt. R2's fingernails were also observed to be dirty, with brown substance under them. On 3/8/24 at 2:19 p.m.,family member (FM)-A stated R2 would not have liked to be seen in dirty clothes. FM-A stated she trimmed R2's nails every two weeks because, "they are always dirty and have blood in them. It makes him feel good. He is concerned about being well kept. When he gets taken care of, he gets so happy, and is so appreciative when I clean his nails or when he gets a haircut. He used to be in the military and liked to look good." FM-A further stated R2 did not use a clothing protector when he ate, and the meal from 3/7/24, "was all over him hours after the meal. It was like four to five hours after the	F 550	does not constitute admission or agreement by the provider of the the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice? R2 is cared for with dignity. R2's clothing was changed and nails cleansed on 3/11/2024. Community associates assist with activities of daily living per the plan of care which includes cleaning resident finger nails and offering clean clothes if soiled. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents of the community will be cared for per care their plan of care which includes the promotion of independence and dignity. All residents residing on the Villa neighborhood have been reviewed for nail cleanliness and are reviewed after meals to ensure clothing is not soiled. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. All nursing associates have been educated to complete nail care per community policy which is to be done in accordance to the bathing schedule and per resident need. All nursing associates have been educated that clothing is to be	

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 03/11/2024

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 550	Continued From page 3 meal. He has his pride and wouldn't want to look like that. I just want to make sure he is kept clean and neat." On 3/8/24 at 3:18 p.m., R2 nails remained dirty with brown matter under the nails, and he was still wearing the soiled shirt. On 3/8/24 at 3:23 p.m., nursing assistant (NA)-A stated NAs provided nail care when they did baths. NA-A stated R2's bath was scheduled on Friday evening. NA-A stated R2's daughter cut R2's nails, but NAs cleaned them, and nails can be cleaned any day if they were dirty. NA-A acknowledged R2's shirt and nails were dirty and stated, "It's not good. I wouldn't feel comfortable in dirty clothes. It doesn't look good. It affects how they feel. He still knows what he looks like." On 3/11/24 at 8:30 a.m., R2 was sitting in the dining room. R2's fingernails on both hands were dirty with brown substance under them. On 3/11/24 at 11:22 a.m., during an observation R2 ate tomato soup, spilled soup on his shirt, and tried to wipe it off with a napkin. On 3/11/24 at 11:54 a.m., NA-C stated R2's nails and shirt were dirty, and the NAs should change the shirt when it was dirty. NA-C stated nails should be cleaned when R2 had a bath. NA-C stated, "[The fingernails] can get cleaned anytime. He scratches himself. It's not good to look like that." R2 looked at NA-C and stated, "They are filthy. " On 3/11/24 at 2:29 p.m., registered nurse (RN)-C stated cleaning nails was an expectation during bath time and as needed. RN-C stated if R2's	F 550	assessed after each meal and clean clothing is to be offered if soiled. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. DON/Designee will audit 5 resident per week to ensure nail care which includes cleaning of fingernails is completed on a resident's bath day. DON/designee will audit 5 residents per week to ensure clean clothes are offered to residents after meals. Results of these audits will be reviewed by the QAPI committee. 5. The date that each deficiency will be corrected. This will be corrected by April 17, 2024	

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 03/11/2024

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 550	Continued From page 4 clothing was soiled, the clothing should have been changed. On 3/11/24 at 3:49 p.m., the director of nursing (DON) stated, "When the resident has dirty clothes on, the staff should offer clean clothes. Nail care is on shower days and as needed. If [R2] called the staff member's attention to it [dirty nails], they should have helped the resident to clean them. The person would not feel good to wear dirty clothes or have dirty nails. Well, that would make him feel uncomfortable. " A policy on dignity was requested and not provided.	F 550		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		4/17/24

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 03/11/2024

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 656	Continued From page 5 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement the comprehensive care plan that included interventions to assist with eating for 1 of 3 residents (R2) reviewed for activities of daily living. Findings include: R2's significant change Minimum Data Set dated 12/11/23 indicated R2 had severe cognitive impairment.	F 656	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice? R2's plan of care and care delivery guide have been reviewed by the clinical manager and nurse practitioner with edits made to ensure R2 gets the appropriate feeding support. 2. How the facility will identify other residents having the potential to be	

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 03/11/2024

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 656	Continued From page 6 R2's Provider Order dated 1/26/24 directed R2 to receive feeding assistance for meals. R2's care plan dated 10/10/23 indicated R2 had inadequate oral intake related to a history of poor appetite and impaired cognition, and R2 required assistance for meal with supervision and encouragement. On 3/8/24 at 4:12 p.m., R2 was observed in the dining room. At the table there was milk, water, an empty jello bowl (which R2 had consumed) and a plate that contained corn, fish, and potatoes. A nursing assistant opened R2's tartar sauce and buttered the bun on his plate. R2 attempted to eat one bite of corn and it dropped down the front of himself. R2 ate his bun, drank his water and milk, and did not attempt to eat the corn, fish or potatoes. Dining staff brought R2 an ice cream cup, removed the lid and R2 proceeded to eat it. At 4:33 pm NA-D took R2's plate. No staff encouraged R2 to eat his meal. On 3/11/24 at 11:22 a.m., R2 ate tomato soup, spilled soup on his shirt, and tried to wipe it off with a napkin. No staff encouraged R2 to eat his meal. On 3/11/24 at 11:42 a.m., family member (FM)-A stated, "No one offered to help him [R2] with his fruit [bowl of peaches]. They only help at the table with the people they sit by." On 3/11/124 at 11:50 a.m., NA-B stated, "He doesn't need any assistance. We just give him his food. I did not know he needed encouragement with his meal. On 3/11/24 at 3:49 p.m., the director of nursing	F 656	affected by the same deficient practice? All residents are assessed on a quarterly basis and with a change of condition related to the amount of assistance they require with feeding. These recommendations are then integrated into their plan of care. Provider's orders, care plans, and care delivery guides on the Villa neighborhood have been audited to ensure integration is complete. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. All clinical managers have been educated to integrate provider's orders into the care being provided on each neighborhood. All nursing associates have been educated on following the care plan and care delivery guide related to feeding assistance. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. DON/designee will audit 5 residents per week at meals to ensure the provider order, care plan, care delivery guide, and the services provided to the resident are aligned. The results of these audits will be shared with quality council. 5. The date that each deficiency will be corrected.	

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 03/11/2024

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 656	Continued From page 7 (DON) stated when a resident required assistance with eating, staff should assist the resident with eating. The facility policy Resident/Family Participation in Care Planning dated 11/28/17 directed care planning included decisions about care and treatment.	F 656	This will be corrected by April 17, 2024	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		4/17/24

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 03/11/2024

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 657	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide quarterly interdisciplinary team (IDT) care conferences for 1 of 5 residents (R6) reviewed for care plan timing and revision. Findings include: R6's quarterly MDS dated 12/13/23, indicated R6 had severe cognitive impairment. R6's medical record indicated quarterly care conferences were held on 3/23/23 and 6/22/23. No care conferences had been held since that time. On 3/11/23 at 2:29 p.m., registered nurse (RN)-C stated the facility typically performed a care conference for each resident the first week after admission, quarterly, and as needs arose. RN-C acknowledged R6 missed several care conferences. On 3/11/24 at 3:24 p.m., the social worker (SW)-A stated, "We have recently had some changes, and one employee didn't work out, partly because she wasn't having and documenting care conferences." SW-A further acknowledged there were no notes for R6's care conferences after 6/22/23, and no care conferences were scheduled for R6. SW-A stated care conferences should be scheduled quarterly. On 3/11/24 at 3:49 p.m., the director of nursing (DON) stated the care conferences should be held quarterly and as needed.	F 657	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice? R6 is a current resident of Benedictine New Brighton and has a scheduled care conference for 4/3/2024. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents in long term care will be audited to ensure care conferences are being held at appropriate intervals. Any resident outside of the appropriate time frame will have a care conference scheduled. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. S Education was provided to the Director of Social Services, Case Management Department and receptionist related to Benedictine policy and regulatory expectations related to the scheduling of care conferences. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING _____ B. WING _____	C 03/11/2024

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 657	Continued From page 9 The facility policy Resident/Family Participation in Care Planning dated 11/28/2017, directed the resident had the right to participate in planning care and treatment.	F 657	The DON/Designee will audit 5 residents per week based on the MDS schedule to ensure quarterly care conferences are being held. The results of these audits will be shared with quality council. 6. The date that each deficiency will be corrected. This will be corrected by April 17, 2024	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care and feeding assistance was provided for 1 of 3 residents (R2) reviewed for activities of daily living (ADLs). Findings include: R2's significant change Minimum Data Set (MDS) dated 1/12/24, indicated R2 had severe cognitive impairment, required supervision for eating, and moderate assistance with personal hygiene. R2's Provider Order dated 1/26/24, directed staff to provide feeding assistance for meals three times daily. R2's Provider Order dated 1/19/24, directed R2's bath day was Friday, and "Licensed nurse to	F 677	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice? R2 has had his finger nails cleaned on 3/11/2024 and is receiving assistance with feeding per his plan of care. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents of the community will be cared for per care their plan of care which includes the promotion of independence and dignity. All residents residing on the Villa neighborhood have been reviewed for nail cleanliness and are reviewed after	4/17/24

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 03/11/2024

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 677	Continued From page 10 complete body audit on resident bath day and document nail[s] in task." R2's care plan dated 10/10/23, indicated R2 required assistance for meal with supervision and encouragement. On 3/8/24 at 1:05 p.m., registered nurse (RN)-A stated R2 used to eat independently but now required assistance. RN-A stated, "We encourage [R2] and sometimes have to just get [R2] get started [to eat.]. [R2] doesn't have the appetite he used to. Staff has to be next to [R2] when he is eating." On 3/8/24 at 2:19 p.m., family member (FM)-A stated R2 had dementia and required assistance in nail care. FM-A stated she cut R2's nails every couple of weeks, but staff should have been cleaning R4's nails in between cutting, during bath time. FM-A stated R2's nails were dirty and had brown matter under them. On 3/8/24 at 3:23 p.m. nursing assistant (NA)-A stated R2's daughter cut his nails, but staff cleaned them. NA-A acknowledged R2's nails were dirty and stated, "It's not good. It doesn't look good. It affects how they feel. He still knows what he looks like." On 3/8/24 at 4:12 p.m., R2 was observed in the dining room. At the table there was milk, water, an empty jello bowl (which R2 had consumed) and a plate that contained corn, fish, and potatoes. A nursing assistant opened R2's tartar sauce and buttered the bun on his plate. R2 attempted to eat one bite of corn and it dropped down the front of himself. R2 ate his bun, drank his water and milk, and did not attempt to eat the	F 677	meals to ensure clothing is not soiled. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. All nursing associates have been educated to complete nail care per community policy which is to be done in accordance to the bathing schedule and per resident need. All nursing associates have been educated to follow the plan of care related to interventions on the care delivery guide which includes the assistance needed with feeding. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. DON/designee will audit 5 residents per week at meals to ensure the provider order, care plan, care delivery guide, and the services provided to the resident are aligned. DON/Designee will audit 5 resident per week to ensure nail care which includes cleaning of fingernails is completed on a resident's bath day. The results of these audits will be shared with QAPI. 5. The date that each deficiency will be corrected. This will be corrected by April 17th, 2024.	

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 03/11/2024

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 677	Continued From page 11 corn, fish or potatoes. Dining staff brought R2 an ice cream cup, removed the lid and R2 proceeded to eat it. At 4:33 pm NA-D took R2's plate. No staff encouraged R2 to eat his meal. On 3/11/24 at 11:22 a.m., R2 was observed eating tomato soup. R2 spilled soup on his shirt. R2 tried to wipe the soup off his shirt with a napkin. No staff encouraged R2 to eat his meal. On 3/11/24 at 11:42 a.m., FM-A was present during the mid-day meal and stated, "No one offered to help with fruit [bowl of peaches]. They only help at the table with the people they sit by." Three staff was observed sitting at one table helping other residents eat. On 3/11/24 at 11:50 a.m., NA-B asked R2 if he was done with his meal, R2 nodded yes. NA-B removed R2's peaches without offering encouragement or assistance to eat them. NA-B stated she did not know R2 required assistance or encouragement to eat. On 3/11/24 at 11:54 a.m., NA-C stated R2 required assistance to eat, but acknowledged staff had not helped R2 eat lunch. NA-C stated R2 ate better with encouragement. NA-C also acknowledged R2 had dirty fingernails. On 3/11/23 at 2:29 p.m., RN-C stated R2 required assistance eating and verified it was in R2's care plan. On 3/11/24 at 3:49 p.m., the director of nursing (DON) stated when a resident required assistance with their meals, if the assessment and care plan indicated they needed assistance, the resident should be assisted. The DON stated	F 677		

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 03/11/2024

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 677	Continued From page 12 nail care was performed on shower days and as needed. The DON stated, "The resident would not feel good to wear dirty clothes or have dirty nails. Well, that would make him feel uncomfortable." The facility policy Activities of Daily Living dated June 2021, directed residents unable to carry out ADLs independently would receive services necessary to maintain good grooming and personal hygiene.	F 677		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755		4/17/24

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 03/11/2024

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 755	Continued From page 13 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed follow safeguards in place to ensure residents received the correct medications for 1 of 3 residents (R4) reviewed for medication error. Findings include: R4's Medicare 5-Day Minimum Data Sheet (MDS) dated 9/4/23 indicated R4 was cognitively intact. R4's Diagnoses List printed 3/11/24, indicated R4 had a diagnosis of glaucoma in both eyes. R4's Provider Orders dated 8/29/23, indicated brimonidine drops (used to lower pressure in the eyes related to glaucoma), 0.2%, administer one drop in each eye twice daily. R4's care plan printed dated 8/30/23, indicated administer medications per doctor's order. On 3/11/24 at 10:22 a.m., R4 stated on 9/7/23, she administered her own eye drops that were left on her tray table by licensed practical nurse (LPN)-A. R4 stated she then discovered they were for someone else. R4 stated the nurse notified the provider, and R4's own eye drops were held for one dose as a result. R4 denied any	F 755	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice? R4 discharged from the community on 9/22/2023 after meeting many of her therapy goals. She had no negative outcomes from the deficient practice. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? All medication errors are thoroughly investigated and root cause is considered with appropriate education, disciplinary action, or other interventions implemented. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. All licensed nurses were educated to the 7 rights of medications administration (right person, right medication, right dose, right time, right route, right reason, and right documentation). All licensed nurses were educated on Benedictine	

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 03/11/2024

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 755	Continued From page 14 ill effects from using the wrong eye drops, and flushed her own eyes after she realized the drops were not her medication. On 3/11/24 at 1:05 p.m., registered nurse (RN)-B stated R4 administered her own eye drops on 9/7/3 at 8:10 p.m., but instead of the prescribed bromodine eye drops, R4 administered dorzalamide eye drops (used to lower pressure in the eyes related to glaucoma). RN-B acknowledged R4 had received another resident's eye drops. RN-B stated R4 had not been assessed to ensure R4 could safely administer her own eye drops. RN-B stated licensed practical nurse (LPN)-A should not have left the room prior to the eye drop administration, and should have checked to ensure R4 had been given the correct medication. RN-B stated LPN-A set up two residents' medications at the same time, and had delivered the wrong medication to R4. On 3/11/24 at 3:49 p.m., the director of nursing (DON) verified R4 received the wrong eye drops on 9/7/23. The facility Administering Medications Policy dated February 2019, direted medications were administered by licensed nurses or trained associates after ensuring the right resident had the right medication.	F 755	self-administration of medication policy. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. DON/designee will audit 5 residents medication pass per week to ensure care plan for medication administration is followed including whether the resident has a self admin assessment completed. The results of these audits will be shared with quality council. 6. The date that each deficiency will be corrected. This will be corrected by April 17, 2024	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 18, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: U9ZH11

Dear Administrator:

The above facility was surveyed on March 8, 2024 through March 11, 2024 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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00940	A. BUILDING: _____ B. WING _____	03/11/2024

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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/8/24 and 3/11/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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

Electronically Signed | 03/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00940	A. BUILDING: _____ B. WING _____	03/11/2024

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
2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H53101592C (MN00099889) H53101593C (MN00100394) H53101647C (MN00099699) H53101591C (MN00100017) H53101609C (MN00098419) Licensing orders were issued at 4658.0405 Subp 3. 4658.0520 Subp 2 F, and 144.651 Subd 5. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00940	A. BUILDING: _____ B. WING _____	03/11/2024

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
2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement the comprehensive care plan that included interventions to assist with eating for 1 of 3 residents (R2) reviewed for activities of daily living. Findings include: R2's significant change Minimum Data Set dated 12/11/23 indicated R2 had severe cognitive impairment. R2's Provider Order dated 1/26/24 directed R2 to receive feeding assistance for meals.	2 565	Corrected.	4/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00940	A. BUILDING: _____ B. WING _____	03/11/2024

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
2 565	Continued From page 3 R2's care plan dated 10/10/23 indicated R2 had inadequate oral intake related to a history of poor appetite and impaired cognition, and R2 required assistance for meal with supervision and encouragement. On 3/8/24 at 4:12 p.m., R2 was observed in the dining room. At the table there was milk, water, an empty jello bowl (which R2 had consumed) and a plate that contained corn, fish, and potatoes. A nursing assistant opened R2's tartar sauce and buttered the bun on his plate. R2 attempted to eat one bite of corn and it dropped down the front of himself. R2 ate his bun, drank his water and milk, and did not attempt to eat the corn, fish or potatoes. Dining staff brought R2 an ice cream cup, removed the lid and R2 proceeded to eat it. At 4:33 pm NA-D took R2's plate. No staff encouraged R2 to eat his meal. On 3/11/24 at 11:22 a.m., R2 ate tomato soup, spilled soup on his shirt, and tried to wipe it off with a napkin. No staff encouraged R2 to eat his meal. On 3/11/24 at 11:42 a.m., family member (FM)-A stated, "No one offered to help him [R2] with his fruit [bowl of peaches]. They only help at the table with the people they sit by." On 3/11/124 at 11:50 a.m., NA-B stated, "He doesn't need any assistance. We just give him his food. I did not know he needed encouragement with his meal. On 3/11/24 at 3:49 p.m., the director of nursing (DON) stated when a resident required assistance with eating, staff should assist the resident with eating.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00940	A. BUILDING: _____ B. WING _____	03/11/2024

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
2 565	Continued From page 4 The facility policy Resident/Family Participation in Care Planning dated 11/28/17 directed care planning included decisions about care and treatment. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care planned interventions are followed. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 565		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care and feeding assistance was provided for 1 of 3 residents (R2) reviewed for activities of daily living (ADLs).	2 860	Corrected	4/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00940	A. BUILDING: _____ B. WING _____	03/11/2024

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
2 860	Continued From page 5 Findings include: R2's significant change Minimum Data Set (MDS) dated 1/12/24, indicated R2 had severe cognitive impairment, required supervision for eating, and moderate assistance with personal hygiene. R2's Provider Order dated 1/26/24, directed staff to provide feeding assistance for meals three times daily. R2's Provider Order dated 1/19/24, directed R2's bath day was Friday, and "Licensed nurse to complete body audit on resident bath day and document nail[s] in task." R2's care plan dated 10/10/23, indicated R2 required assistance for meal with supervision and encouragement. On 3/8/24 at 1:05 p.m., registered nurse (RN)-A stated R2 used to eat independently but now required assistance. RN-A stated, "We encourage [R2] and sometimes have to just get [R2] get started [to eat.]. [R2] doesn't have the appetite he used to. Staff has to be next to [R2] when he is eating." On 3/8/24 at 2:19 p.m., family member (FM)-A stated R2 had dementia and required assistance in nail care. FM-A stated she cut R2's nails every couple of weeks, but staff should have been cleaning R4's nails in between cutting, during bath time. FM-A stated R2's nails were dirty and had brown matter under them. On 3/8/24 at 3:23 p.m. nursing assistant (NA)-A stated R2's daughter cut his nails, but staff cleaned them. NA-A acknowledged R2's nails	2 860		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00940	A. BUILDING: _____ B. WING _____	03/11/2024

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
2 860	Continued From page 6 were dirty and stated, "It's not good. It doesn't look good. It affects how they feel. He still knows what he looks like." On 3/8/24 at 4:12 p.m., R2 was observed in the dining room. At the table there was milk, water, an empty jello bowl (which R2 had consumed) and a plate that contained corn, fish, and potatoes. A nursing assistant opened R2's tartar sauce and buttered the bun on his plate. R2 attempted to eat one bite of corn and it dropped down the front of himself. R2 ate his bun, drank his water and milk, and did not attempt to eat the corn, fish or potatoes. Dining staff brought R2 an ice cream cup, removed the lid and R2 proceeded to eat it. At 4:33 pm NA-D took R2's plate. No staff encouraged R2 to eat his meal. On 3/11/24 at 11:22 a.m., R2 was observed eating tomato soup. R2 spilled soup on his shirt. R2 tried to wipe the soup off his shirt with a napkin. No staff encouraged R2 to eat his meal. On 3/11/24 at 11:42 a.m., FM-A was present during the mid-day meal and stated, "No one offered to help with fruit [bowl of peaches]. They only help at the table with the people they sit by." Three staff was observed sitting at one table helping other residents eat. On 3/11/24 at 11:50 a.m., NA-B asked R2 if he was done with his meal, R2 nodded yes. NA-B removed R2's peaches without offering encouragement or assistance to eat them. NA-B stated she did not know R2 required assistance or encouragement to eat. On 3/11/24 at 11:54 a.m., NA-C stated R2 required assistance to eat, but acknowledged staff had not helped R2 eat lunch. NA-C stated	2 860		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00940	A. BUILDING: _____ B. WING _____	03/11/2024

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
2 860	Continued From page 7 R2 ate better with encouragement. NA-C also acknowledged R2 had dirty fingernails. On 3/11/23 at 2:29 p.m., RN-C stated R2 required assistance eating and verified it was in R2's care plan. On 3/11/24 at 3:49 p.m., the director of nursing (DON) stated when a resident required assistance with their meals, if the assessment and care plan indicated they needed assistance, the resident should be assisted. The DON stated nail care was performed on shower days and as needed. The DON stated, "The resident would not feel good to wear dirty clothes or have dirty nails. Well, that would make him feel uncomfortable." The facility policy Activities of Daily Living dated June 2021, directed residents unable to carry out ADLs independently would receive services necessary to maintain good grooming and personal hygiene. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents who needs assistance with ADLS were provided assistance. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00940	A. BUILDING: _____ B. WING _____	03/11/2024

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
21805	Continued From page 8	21805		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity was maintained for 1 of 3 residents (R2) reviewed for activities of daily living. Findings include: R2's significant change Minimum Data Set (MDS) dated 1/12/24, indicated severe cognitive impairment and R2 required moderate assistance with personal hygiene (helper does less than half the effort). R2's Diagnosis List printed 3/11/24, indicated diagnoses of dementia and muscle weakness. R2's Provider Order dated 1/26/24, directed staff to provide R2 with feeding assistance for meals three times daily. R2's care plan dated 10/10/23, indicated R2 required assistance with grooming and bathing. On 3/8/23 at 1:03 p.m., R2 was observed in his wheelchair in the dining room. R2's clothes were soiled with white substance splattered on his pajama pants, and food stains on his shirt. R2's fingernails were also observed to be dirty, with	21805	Corrected.	4/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00940	A. BUILDING: _____ B. WING _____	03/11/2024

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
21805	Continued From page 9 brown substance under them. On 3/8/24 at 2:19 p.m.,family member (FM)-A stated R2 would not have liked to be seen in dirty clothes. FM-A stated she trimmed R2's nails every two weeks because, "they are always dirty and have blood in them. It makes him feel good. He is concerned about being well kept. When he gets taken care of, he gets so happy, and is so appreciative when I clean his nails or when he gets a haircut. He used to be in the military and liked to look good." FM-A further stated R2 did not use a clothing protector when he ate, and the meal from 3/7/24, "was all over him hours after the meal. It was like four to five hours after the meal. He has his pride and wouldn't want to look like that. I just want to make sure he is kept clean and neat." On 3/8/24 at 3:18 p.m., R2 nails remained dirty with brown matter under the nails, and he was still wearing the soiled shirt. On 3/8/24 at 3:23 p.m., nursing assistant (NA)-A stated NAs provided nail care when they did baths. NA-A stated R2's bath was scheduled on Friday evening. NA-A stated R2's daughter cut R2's nails, but NAs cleaned them, and nails can be cleaned any day if they were dirty. NA-A acknowledged R2's shirt and nails were dirty and stated, "It's not good. I wouldn't feel comfortable in dirty clothes. It doesn't look good. It affects how they feel. He still knows what he looks like." On 3/11/24 at 8:30 a.m., R2 was sitting in the dining room. R2's fingernails on both hands were dirty with brown substance under them. On 3/11/24 at 11:22 a.m., during an observation R2 ate tomato soup, spilled soup on his shirt, and	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00940	A. BUILDING: _____ B. WING _____	03/11/2024

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
21805	Continued From page 10 tried to wipe it off with a napkin. On 3/11/24 at 11:54 a.m., NA-C stated R2's nails and shirt were dirty, and the NAs should change the shirt when it was dirty. NA-C stated nails should be cleaned when R2 had a bath. NA-C stated, "[The fingernails] can get cleaned anytime. He scratches himself. It's not good to look like that." R2 looked at NA-C and stated, "They are filthy. " On 3/11/24 at 2:29 p.m., registered nurse (RN)-C stated cleaning nails was an expectation during bath time and as needed. RN-C stated if R2's clothing was soiled, the clothing should have been changed. On 3/11/24 at 3:49 p.m., the director of nursing (DON) stated, "When the resident has dirty clothes on, the staff should offer clean clothes. Nail care is on shower days and as needed. If [R2] called the staff member's attention to it [dirty nails], they should have helped the resident to clean them. The person would not feel good to wear dirty clothes or have dirty nails. Well, that would make him feel uncomfortable. " A policy on dignity was requested and not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure dignity is maintained with all residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00940	A. BUILDING: _____ B. WING _____	03/11/2024

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
21805	Continued From page 11 compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		