DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered
July 17, 2024

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

RE: CCN: 245310
Cycle Start Date: May 30, 2024

Dear Administrator:

On July 11, 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

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Electronically delivered

July 17, 2024

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

Re: Reinspection Results
Event ID:  WXBG12

Dear Administrator:

On July 11, 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 May 30, 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

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
June 12, 2024

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

RE: CCN: 245310
Cycle Start Date: May 30, 2024

Dear Administrator:

On May 30, 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:

Susie Haben, Rapid Response Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by August 30, 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 November 30, 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 05/30/2024 |

| 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 |
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| F 000 | INITIAL COMMENTS<br><br>On 5/28/24 through 5/30/24, 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.<br><br>The following complaints were reviewed:<br>H53104083C (MN103592) with a deficiency issued at F686.<br>H53104005C (MN103554) with deficiencies issued at F686, F689.<br>H53104006C (MN103521)<br>H53104090C (MN103408) with a deficiency issued at F686.<br>H53103311C (MN102618)<br>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.<br><br>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 686 SS=D | .<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with | F 686 | | 7/3/24 |

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

Electronically Signed | 06/17/2024

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.

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| F 686 | Continued From page 1<br>professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to implement care planned interventions to prevent worsening of existing pressure ulcers for 1 of 3 residents (R4) reviewed with a pressure ulcer.<br><br>Findings include:<br><br>R4's Resident Face Sheet indicated admission to facility on 8/3/23. The face sheet indicated diagnosis that included dementia, anxiety, muscle weakness and a stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister) pressure ulcer.<br><br>R4's significant change Minimum Data Set (MDS) dated 5/7/24, identified severe cognitive impairment and indicated he displayed no behaviors. The MDS indicated R4 was dependent on staff for putting on and taking off footwear and identified an unstageable (a full thickness tissue loss where the depth of the wound or bed sore is completely obscured by eschar [dead tissue] in the wound bed) pressure ulcer.<br><br>R4's care plan dated 8/4/23, identified a deep | F 686 | How corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br>- R4's pressure ulcers are stable and healing. They have not deteriorated as a result of this deficient practice. Resident recently graduated from hospice care. Residents care plans related to skin and care delivery guide have been reviewed and update with appropriate interventions.<br>How the facility will identify other residents having the potential to be affected by the same deficient practice?<br>- All residents who are residing in the community with a pressure ulcer have been reviewed for appropriate care plan interventions and those interventions are on the care delivery guide.<br>What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur?<br>- All nurses and NARS have been educated on implementing the interventions on the care delivery guides and documenting refusals of care.<br>- The IDT team is reviewing all residents with pressure ulcers weekly to | |

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| F 686 | Continued From page 2<br>tissue injury on his right heel with potential for further pressure injuries related to need for assistance with cares, mobility and toileting. Care planned interventions included an air mattress and bilateral Prevalon heel protectors in bed and when up in chair. The care plan identified a self care deficit and indicated R4 required assistance for transfers and grooming.<br><br>R4's nursing assistant (NA) care guide undated, directed staff to apply bilateral heel protectors in bed and wheel chair and identified the use of an air mattress for right heel wound.<br><br>R4's Resident Progress Note dated 5/21/24, indicated impaired skin integrity on right heel and identified a 2.0 centimeter (cm) by 2.0 cm unstageable ulcer. Prevalon heel protectors to bilateral heels while in bed and wheelchair.<br><br>During observation on 5/29/24 at 11:43 a.m., R4 was seated in a wheel chair in the dining room. R4 was wearing red gripper socks on both feet, no Prevalon boots.<br><br>During interview on 5/29/24 at 11:58 a.m., licensed practical nurse (LPN)-A stated R4 was supposed to be wearing Prevalon boots. At 12:13 p.m. NA-A was asked about the Prevalon boots and said R4 should be wearing them. At 12:14 p.m. a Prevalon boot was observed in a box at the end of R4's bed.<br><br>During observation on 5/30/24 at 9:03 a.m., R4 was seated at the table in the dining room wearing gripper socks but no Prevalon boots. During observation of R4's room at approximately 9:45 a.m., R4's bed did not have an air mattress and the Prevalon boot was in a box at the end of | F 686 | ensure the skin care plan and care delivery guide match related to interventions.<br>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?<br>- The DON/designee will audit three residents per week to ensure the care plan matches the care delivery guides as well as the verifying the interventions are in place on the resident or in the resident room. Audits will occur for 4 weeks and will be reviewed by the QAPI committee.<br>The date that each deficiency will be corrected?<br>- This will be corrected on 7/3/2024 | |

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| F 686 | Continued From page 3<br>his bed.<br><br>During interview on 5/30/24 at 9:48 a.m., NA-B stated R4 had a wound on his heel. NA-B said R4 would say no to the boots in the morning but would allow them in the afternoon. NA-B said if he refused staff would tell the nurse and the nurse would document at the end of the shift.<br><br>R4's medical record lacked documentation that R4 refused the Prevalon boots.<br><br>During interview on 5/30/24 at 11:20 a.m., registered nurse (RN)-A and the director of nursing (DON) were interviewed. RN-A stated R4 had Prevalon boots he was supposed to wear due to his heel ulcer. RN-A said R4 used them in bed but would try to take them off when he was in the chair but she still expected staff to offer them. RN-A stated the air mattress had been removed when R4 had been discontinued from hospice cares and had not been replaced. RN-A and the DON acknowledged R4's medical record lacked evidence he refused the Prevalon boots.<br><br>Facility Policy Prevention and Treatment of Skin Breakdown dated 2018, indicated if a resident is admitted with impaired skin integrity or a new pressure ulcer wound develops the licensed nurse implements the following items: Evaluate current pressure reduction interventions and revise resident centered care plan. Re-evaluate plan of care as appropriate. Documentation reflects areas addressed above. | F 686 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents. | F 689 | | 7/3/24 |

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| F 689 | Continued From page 4<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed demonstrate root cause analysis, failed to perform ongoing analysis and failed to implement individualized interventions to reduce the risk for falls for 1 of 3 resident (R5) who sustained multiple falls since admission to the facility.<br><br>Findings include:<br><br>R5's Resident Face Sheet indicated she admitted to the facility on 3/12/24, with diagnosis that included failure to thrive, weakness, cognitive deficits and a history of falls.<br><br>R5's Observation Detail List Report dated 3/13/24, indicated she was alert and oriented, had adequate vision and required the use of assistive devices, impaired mobility and/or assist with toileting. Medication use included antihypertensives. History of falls in the last three months indicated none. Fall risk score was seven which indicated R5 was not at risk for falls.<br>Observation Detail List Report dated 3/30/24, indicated R5 sustained one to two falls in the past three months and indicated a score of 9 which indicated R5 was not at risk for falls.<br><br>R5's significant change Minimum Data Set (MDS) dated 4/4/24, identified intact cognition, did not | F 689 | How corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br>- R5s history of falls has been reviewed by the IDT team. Root cause analysis completed. Additional interventions to reduce falls risk have been implemented. Care plan and care delivery guide updated to reflect plan of care.<br>How the facility will identify other residents having the potential to be affected by the same deficient practice?<br>- All residents with three or more falls in the past 90 days will be reviewed by the IDT team to ensure root cause is being identified and subsequent interventions are in place.<br>What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur?<br>- All residents who have a fall are being reviewed daily by the IDT Team.<br>- IDT notes are being written to ensure the intervention that we believe impacts root cause is clearly highlighted.<br>- All members of the IDT team have been educated on root cause analysis, the 5 whys process and various options that may be effective interventions. | |

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| F 689 | Continued From page 5<br>refuse cares and indicated she required substantial/maximal assistance for toileting and partial/moderate assistance for transfers. The MDS indicated R4 had sustained two or more falls since the prior assessment.<br><br>R5's care area assessment dated 4/4/24, identified falls. Conclusions about the root cause, contributing factors related to previous falls was left blank. Clinical performance limitations: balance, gait, strength, muscle endurance; was left blank. Medications; left blank. Internal risk factors, circulatory; left blank. Internal risk factors, neuromuscular/functions; left blank. All other internal risk factors left blank. Environmental factors left blank. Analysis indicated R5 triggered for falls related to needing assistance with cares, mobility, toileting, incontinence due to urinary tract infection, anemia, obesity, cognitive decline. Call light in reach and remind to use it. History of frequent falls at home.<br><br>R5's care plan dated 4/10/24, identified a risk for falls. The care included the following interventions implemented on 3/18/24: call light and personal items in reach, ambulation to promote strengthening, room free from clutter, adequate lighting, bed low/appropriate height to res feet on floor, toilet upon rising, before and after meals, in the evening and overnight as needed, grab bars, gripper socks on when in bed. 3/20/24, the care plan was updated to include offer toileting if awake at 5:00 a.m.<br><br>R5's Event Reports and correlating Resident Progress Notes identified the following falls:<br><br>3/18/24 at 5:05 a.m., R5 was found on the floor in her bathroom. R5 reported she was trying to get | F 689 | How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?<br>- The DON/designee will audit three falls per week to ensure root cause is being discussed, interventions are being documented by the IDT team and carried through to the care plan, care delivery guide, and to the care being received.<br><br>The date that each deficiency will be corrected?<br>- This will be corrected on 7/3/2024 | |

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| F 689 | Continued From page 6<br>to the bathroom.<br>Progress note dated 3/20/24, indicated the interdisciplinary tam (IDT) met to review the fall and intervention to toilet R5 in early morning hours was implemented.<br><br>3/28/24 at 7:56 a.m., R5 was found on the floor in her room. R5 reported she went to get clothes from her closet and her legs gave out causing her to slide to the floor. Progress note dated 4/1/24, indicated IDT met to review the fall. On assessment R5 was lying on her back on the floor with her feet stretched toward the nightstand and her head on a pillow. Actual time of the fall was unknown. R5 was able to verbalize her needs but did not use the call light consistently. R5 was re-educated on call light use and waiting for assistance. Writer offered resident to be assisted to wake early and she refused.<br><br>4/14/24 at 12:58 p.m., R5 fell in her room. R5 reported she was trying to get her shoes from under her bed. Progress note dated 4/16/24, indicated IDT met to review the fall. R5 reported she was trying to reach her shoes using the reacher. Call light was within reach but R5 had not used it, R5 was reminded to use call light and request assistance.<br><br>4/16/24 at 8:32 a.m. R5 fell in her bathroom. R5 reported she was changing her clothes. Progress note indicated on 4/23/24, IDT met to review the fall. Staff reported R5 had her bathroom light on and was calling for help. R5 reported she slipped from the toilet. R5 was educated on using the call light and waiting for assistance. Signage was placed in the room to remind R5 to ask for assistance. | F 689 | | |

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| F 689 | Continued From page 7 | F 689 | | |

4/27/24 at 6:06 a.m. R5 fell in her room. R5 reported she was trying to get to the bathroom.

4/29/24 at 5:50 a.m. R5 fell in her room and was unable to report what she was trying to do. R5 had a laceration below her right eyebrow.

R5's Resident Progress Note dated 5/2/24, indicated IDT met to review falls on 4/27/24 and 4/29/24. The first fall R5 was observed sliding down the bed and fell before staff could intervene. The second fall R5 was observed lying on the floor next to her bed and was unable to state what she was trying to do. R5's gown was saturated with urine. R5 sustained a 2.5 centimeter laceration to her right eye that was actively bleeding. R5 was alert with intermittent confusion as evidence by R5 sating she could take herself in the bathroom and dress herself. R5 agreed to to allow staff assist but would forget to ask. Continue to remind R5 to ask for help and wait.

5/4/24 at 3:13 p.m. fell in her room. R5 reported she came from the bathroom and was about to sit in the wheelchair and lost her balance. Progress note dated 5/13/24, indicated IDT met to review the fall. R5's call light had not been used. Staff will continue to educate on call light.

5/15/24 at 2:19 p.m. R5 fell in her room and reported she had been transferring from the bed to the wheelchair and lost her balance. Progress note dated 5/28/24, indicated IDT met to review the fall. Staff reported R5 was observed on the floor at 12:10 p.m. by another staff who was passing by. Call light was not used and wheelchair was not locked. R5 had signage in room to ask for assistance which was not being

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245310 | A. BUILDING _____ B. WING _____ | C 05/30/2024 |

| 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 |
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| F 689 | Continued From page 8<br>utilized due to R5's impaired cognition. No additional intervention was identified.<br><br>During observation on 5/30/24 at 8:48 a.m., R5 was lying in bed with her eyes closed. At 10:00 a.m. R5 was up in her wheelchair in the dining room.<br><br>During interview on 5/30/24 at 10:00 a.m., R5 stated she had been at the facility for about a year and said it was going well. R5 stated she usually got up early, "but not today." R5 denied having any concerns related to falling.<br><br>During interview on 5/30/24 at approximately 10:10 a.m., NA-C said she was on-call and did not know R5 very well. NA-C said she did not know R5's fall interventions but could look on the care plan to find them.<br><br>During interview on 5/30/24 at 10:14 a.m., NA-D stated she was not normally working when R5 fell. NA-D stated R5's fall interventions included a low bed, toilet her as much as possible and letting her know her call light was in reach. NA-D stated R5 could use her call light and did well waiting and being patient. NA-D said R5 was a late sleeper and if they got her up early she fell asleep in her chair.<br><br>On 5/30/24 at 11:30 a.m. the director of nursing (DON) and registered nurse (RN)-A were interviewed. The DON stated the IDT met daily Monday through Friday to review falls. The DON stated they reviewed the cause of the falls, if an injury occurred and if the care plan had been followed at the time of the fall. The DON said they established the root cause of the fall then brainstormed possible interventions. RN-A stated | F 689 | | |

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| F 689 | Continued From page 9<br>R5 admitted on 3/12/24 and fell on 3/18/24. RN-A said at that time they were just getting to know her and her routine. The DON said they implemented toileting in the early morning and encourage call light use. The DON stated when R5 fell again they determined she did not use her call light consistently so they provided re-education. When asked about further intervention, RN-A stated the signage reminding R5 to use her call light was removed because it had not been effective. The DON stated he had been talking to the corporate office to tell them interventions were not working and ask what they thought was best. In regard to performing ongoing analysis of R5's falls, the DON stated they performed an assessment when the residents admitted and said they had planned to review R5 "this week."<br><br>"Facility Policy Integrated Fall Management dated 20xx, indicated residents are assessed for their risk for falls upon admission, significant change and quarterly, Residents with risk for falling will have interventions implemented through the resident centered care plan. Residents at risk for falls have an individualized, resident centered care plan developed. Interventions are based on the finding of the fall risk assessment. The IDT reviews the falls and and may if needed implement additional interventions." | F 689 | | |

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
June 12, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: WXBG11

Dear Administrator:

The above facility was surveyed on May 28, 2024 through May 30, 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:

Susie Haben, Rapid Response Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 _____ | 05/30/2024 |

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

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|---|---|---|---|---|
| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 5/28/24 through 5/30/24, 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 order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and | 2 000 | | |

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| 2 000 | Continued From page 1<br>identify the date when they will be completed.<br><br>The following complaints were reviewed:<br>H53104083C (MN103592) with a licensing order issued at 0830.<br>H53104005C (MN103554) with a licensing order issued at 0830.<br>H53104006C (MN103521)<br>H53104090C (MN103408) with a licensing order issued at 0830.<br>H53103311C (MN102618)<br>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.<br><br>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 | 2 000 | | |

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| 2 000 | Continued From page 2<br><br>heading completion date, the date your orders will 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.<br><br>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 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>ACCIDENTS<br><br>Based on observation, interview and document review the facility failed demonstrate root cause analysis, failed to perform ongoing analysis and failed to implement individualized interventions to | 2 830 | Corrected | 7/3/24 |

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|---|---|---|---|---|
| 2 830 | Continued From page 3<br><br>reduce the risk for falls for 1 of 3 resident (R5) who sustained multiple falls since admission to the facility.<br><br>Findings include:<br><br>R5's Resident Face Sheet indicated she admitted to the facility on 3/12/24, with diagnosis that included failure to thrive, weakness, cognitive deficits and a history of falls.<br><br>R5's Observation Detail List Report dated 3/13/24, indicated she was alert and oriented, had adequate vision and required the use of assistive devices, impaired mobility and/or assist with toileting. Medication use included antihypertensives. History of falls in the last three months indicated none. Fall risk score was seven which indicated R5 was not at risk for falls. Observation Detail List Report dated 3/30/24, indicated R5 sustained one to two falls in the past three months and indicated a score of 9 which indicated R5 was not at risk for falls.<br><br>R5's significant change Minimum Data Set (MDS) dated 4/4/24, identified intact cognition, did not refuse cares and indicated she required substantial/maximal assistance for toileting and partial/moderate assistance for transfers. The MDS indicated R4 had sustained two or more falls since the prior assessment.<br><br>R5's care area assessment dated 4/4/24, identified falls. Conclusions about the root cause, contributing factors related to previous falls was left blank. Clinical performance limitations: balance, gait, strength, muscle endurance; was left blank. Medications; left blank. Internal risk factors, circulatory; left blank. Internal risk factors, neuromuscular/functions; left blank. All other | 2 830 | | |

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| 2 830 | Continued From page 4<br><br>internal risk factors left blank. Environmental factors left blank. Analysis indicated R5 triggered for falls related to needing assistance with cares, mobility, toileting, incontinence due to urinary tract infection, anemia, obesity, cognitive decline. Call light in reach and remind to use it. History of frequent falls at home.<br><br>R5's care plan dated 4/10/24, identified a risk for falls. The care included the following interventions implemented on 3/18/24: call light and personal items in reach, ambulation to promote strengthening, room free from clutter, adequate lighting, bed low/appropriate height to res feet on floor, toilet upon rising, before and after meals, in the evening and overnight as needed, grab bars, gripper socks on when in bed. 3/20/24, the care plan was updated to include offer toileting if awake at 5:00 a.m.<br><br>R5's Event Reports and correlating Resident Progress Notes identified the following falls:<br><br>3/18/24 at 5:05 a.m., R5 was found on the floor in her bathroom. R5 reported she was trying to get to the bathroom.<br>Progress note dated 3/20/24, indicated the interdisciplinary tam (IDT) met to review the fall and intervention to toilet R5 in early morning hours was implemented.<br><br>3/28/24 at 7:56 a.m., R5 was found on the floor in her room. R5 reported she went to get clothes from her closet and her legs gave out causing her to slide to the floor. Progress note dated 4/1/24, indicated IDT met to review the fall. On assessment R5 was lying on her back on the floor with her feet stretched toward the nightstand and her head on a pillow. Actual time of the fall was unknown. R5 was able to verbalize her needs but | 2 830 | | |

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|---|---|---|---|---|
| 2 830 | Continued From page 5<br><br>did not use the call light consistently. R5 was re-educated on call light use and waiting for assistance. Writer offered resident to be assisted to wake early and she refused.<br><br>4/14/24 at 12:58 p.m., R5 fell in her room. R5 reported she was trying to get her shoes from under her bed. Progress note dated 4/16/24, indicated IDT met to review the fall. R5 reported she was trying to reach her shoes using the reacher. Call light was within reach but R5 had not used it, R5 was reminded to use call light and request assistance.<br><br>4/16/24 at 8:32 a.m. R5 fell in her bathroom. R5 reported she was changing her clothes. Progress note indicated on 4/23/24, IDT met to review the fall. Staff reported R5 had her bathroom light on and was calling for help. R5 reported she slipped from the toilet. R5 was educated on using the call light and waiting for assistance. Signage was placed in the room to remind R5 to ask for assistance.<br><br>4/27/24 at 6:06 a.m. R5 fell in her room. R5 reported she was trying to get to the bathroom.<br><br>4/29/24 at 5:50 a.m. R5 fell in her room and was unable to report what she was trying to do. R5 had a laceration below her right eyebrow.<br><br>R5's Resident Progress Note dated 5/2/24, indicated IDT met to review falls on 4/27/24 and 4/29/24. The first fall R5 was observed sliding down the bed and fell before staff could intervene. The second fall R5 was observed lying on the floor next to her bed and was unable to state what she was trying to do. R5's gown was saturated with urine. R5 sustained a 2.5 centimeter laceration to her right eye that was | 2 830 | | |

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| 2 830 | Continued From page 6<br><br>actively bleeding. R5 was alert with intermittent confusion as evidence by R5 sating she could take herself in the bathroom and dress herself. R5 agreed to to allow staff assist but would forget to ask. Continue to remind R5 to ask for help and wait.<br><br>5/4/24 at 3:13 p.m. fell in her room. R5 reported she came from the bathroom and was about to sit in the wheelchair and lost her balance. Progress note dated 5/13/24, indicated IDT met to review the fall. R5's call light had not been used. Staff will continue to educate on call light.<br><br>5/15/24 at 2:19 p.m. R5 fell in her room and reported she had been transferring from the bed to the wheelchair and lost her balance. Progress note dated 5/28/24, indicated IDT met to review the fall. Staff reported R5 was observed on the floor at 12:10 p.m. by another staff who was passing by. Call light was not used and wheelchair was not locked. R5 had signage in room to ask for assistance which was not being utilized due to R5's impaired cognition. No additional intervention was identified.<br><br>During observation on 5/30/24 at 8:48 a.m., R5 was lying in bed with her eyes closed. At 10:00 a.m. R5 was up in her wheelchair in the dining room.<br><br>During interview on 5/30/24 at 10:00 a.m., R5 stated she had been at the facility for about a year and said it was going well. R5 stated she usually got up early, "but not today." R5 denied having any concerns related to falling.<br><br>During interview on 5/30/24 at approximately 10:10 a.m., NA-C said she was on-call and did not know R5 very well. NA-C said she did not | 2 830 | | |

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| 2 830 | Continued From page 7<br><br>know R5's fall interventions but could look on the care plan to find them.<br><br>During interview on 5/30/24 at 10:14 a.m., NA-D stated she was not normally working when R5 fell. NA-D stated R5's fall interventions included a low bed, toilet her as much as possible and letting her know her call light was in reach. NA-D stated R5 could use her call light and did well waiting and being patient. NA-D said R5 was a late sleeper and if they got her up early she fell asleep in her chair.<br><br>On 5/30/24 at 11:30 a.m. the director of nursing (DON) and registered nurse (RN)-A were interviewed. The DON stated the IDT met daily Monday through Friday to review falls. The DON stated they reviewed the cause of the falls, if an injury occurred and if the care plan had been followed at the time of the fall. The DON said they established the root cause of the fall then brainstormed possible interventions. RN-A stated R5 admitted on 3/12/24 and fell on 3/18/24. RN-A said at that time they were just getting to know her and her routine. The DON said they implemented toileting in the early morning and encourage call light use. The DON stated when R5 fell again they determined she did not use her call light consistently so they provided re-education. When asked about further intervention, RN-A stated the signage reminding R5 to use her call light was removed because it had not been effective. The DON stated he had been talking to the corporate office to tell them interventions were not working and ask what they thought was best. In regard to performing ongoing analysis of R5's falls, the DON stated they performed an assessment when the residents admitted and said they had planned to review R5 "this week." | 2 830 | | |

| 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 _____ | 05/30/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 2 830 | Continued From page 8<br><br>"Facility Policy Integrated Fall Management dated 20xx, indicated residents are assessed for their risk for falls upon admission, significant change and quarterly, Residents with risk for falling will have interventions implemented through the resident centered care plan. Residents at risk for falls have an individualized, resident centered care plan developed. Interventions are based on the finding of the fall risk assessment. The IDT reviews the falls and and may if needed implement additional interventions."<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.<br><br>Pressure Ulcers<br><br>Based on observation, interview and document review the facility failed to implement care planned interventions to prevent worsening of existing pressure ulcers for 1 of 3 residents (R4) reviewed with a pressure ulcer.<br><br>Findings include:<br><br>R4's Resident Face Sheet indicated admission to | 2 830 | | |

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| 2 830 | Continued From page 9<br><br>facility on 8/3/23. The face sheet indicated diagnosis that included dementia, anxiety, muscle weakness and a stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister) pressure ulcer.<br><br>R4's significant change Minimum Data Set (MDS) dated 5/7/24, identified severe cognitive impairment and indicated he displayed no behaviors. The MDS indicated R4 was dependent on staff for putting on and taking off footwear and identified an unstageable (a full thickness tissue loss where the depth of the wound or bed sore is completely obscured by eschar [dead tissue] in the wound bed) pressure ulcer.<br><br>R4's care plan dated 8/4/23, identified a deep tissue injury on his right heel with potential for further pressure injuries related to need for assistance with cares, mobility and toileting. Care planned interventions included an air mattress and bilateral Prevalon heel protectors in bed and when up in chair. The care plan identified a self care deficit and indicated R4 required assistance for transfers and grooming.<br><br>R4's nursing assistant (NA) care guide undated, directed staff to apply bilateral heel protectors in bed and wheel chair and identified the use of an air mattress for right heel wound.<br><br>R4's Resident Progress Note dated 5/21/24, indicated impaired skin integrity on right heel and identified a 2.0 centimeter (cm) by 2.0 cm unstageable ulcer. Prevalon heel protectors to bilateral heels while in bed and wheelchair.<br><br>During observation on 5/29/24 at 11:43 a.m., R4 | 2 830 | | |

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| 2 830 | Continued From page 10<br><br>was seated in a wheel chair in the dining room. R4 was wearing red gripper socks on both feet, no Prevalon boots.<br><br>During interview on 5/29/24 at 11:58 a.m., licensed practical nurse (LPN)-A stated R4 was supposed to be wearing Prevalon boots. At 12:13 p.m. NA-A was asked about the Prevalon boots and said R4 should be wearing them. At 12:14 p.m. a Prevalon boot was observed in a box at the end of R4's bed.<br><br>During observation on 5/30/24 at 9:03 a.m., R4 was seated at the table in the dining room wearing gripper socks but no Prevalon boots. During observation of R4's room at approximately 9:45 a.m., R4's bed did not have an air mattress and the Prevalon boot was in a box at the end of his bed.<br><br>During interview on 5/30/24 at 9:48 a.m., NA-B stated R4 had a wound on his heel. NA-B said R4 would say no to the boots in the morning but would allow them in the afternoon. NA-B said if he refused staff would tell the nurse and the nurse would document at the end of the shift.<br><br>R4's medical record lacked documentation that R4 refused the Prevalon boots.<br><br>During interview on 5/30/24 at 11:20 a.m., registered nurse (RN)-A and the director of nursing (DON) were interviewed. RN-A stated R4 had Prevalon boots he was supposed to wear due to his heel ulcer. RN-A said R4 used them in bed but would try to take them off when he was in the chair but she still expected staff to offer them. RN-A stated the air mattress had been removed when R4 had been discontinued from hospice cares and had not been replaced. RN-A and the | 2 830 | | |

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| 2 830 | Continued From page 11<br><br>DON acknowledged R4's medical record lacked evidence he refused the Prevalon boots.<br><br>Facility Policy Prevention and Treatment of Skin Breakdown dated 2018, indicated if a resident is admitted with impaired skin integrity or a new pressure ulcer wound develops the licensed nurse implements the following items: Evaluate current pressure reduction interventions and revise resident centered care plan. Re-evaluate plan of care as appropriate. Documentation reflects areas addressed above.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |