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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Health Center Innsbruck	1101 Black Oak Drive New Brighton, MN 55112

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 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 [DATE], 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 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. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 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 dated dated [DATE] indicated R2 had severe cognitive impairment. 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 (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.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 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 [DATE], 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. 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.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 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 [DATE], 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 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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 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 [DATE] 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 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.