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	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

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35569 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. Findings include: 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. R4's significant change Minimum Data Set (MDS) dated [DATE], 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. 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. 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. 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. 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. (continued on next page)

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

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	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

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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. R4's medical record lacked documentation that R4 refused the Prevalon boots. 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. 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.

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	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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35569 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. Findings include: R5's Resident Face Sheet indicated she admitted to the facility on [DATE], with diagnosis that included failure to thrive, weakness, cognitive deficits and a history of falls. 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. R5's significant change Minimum Data Set (MDS) dated [DATE], 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. R5's care area assessment dated [DATE], 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. 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. R5's Event Reports and correlating Resident Progress Notes identified the following falls: 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. (continued on next page)

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	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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Progress note dated 3/20/24, indicated the interdisciplinary [NAME] (IDT) met to review the fall and intervention to toilet R5 in early morning hours was implemented. 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. 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. 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. 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 utilized due to R5's impaired cognition. No additional intervention was identified. 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. (continued on next page)

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	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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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. 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. 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. 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 [DATE] and fell on [DATE]. 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. 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.