DEPARTMENT OF HEALTH AND HUMAN SERVICES | CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 0K4H
Facility ID: 00352

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245459**

2.STATE VENDOR OR MEDICAID NO.
(L2) **787477100**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY WINSTED**
(L4) **551 FOURTH STREET NORTH**
(L5) **WINSTED, MN** (L6) **55395**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2011**

6. DATE OF SURVEY **04/07/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA
02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Austin Fry, HFE NE II 04/07/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 04/21/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/15/2015
(L33)

Posted 04/21/2015 Co.

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245459
April 17, 2015

Ms. Terry Rieck, Administrator
Benedictine Living Community, Winsted
551 Fourth Street North
Winsted, Minnesota 55395-0750

Dear Ms. Rieck:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 12, 2015 the above facility is certified for or recommended for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

April 17, 2015

Ms. Terry Rieck, Administrator
Benedictine Living Community, Winsted
551 Fourth Street North
Winsted, Minnesota 55395-0750

RE: Project Number S5459025

Dear Ms. Rieck:

On March 4, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 12, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 7, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 17, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 12, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 12, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 12, 2015, effective March 12, 2015 and therefore remedies outlined in our letter to you dated March 4, 2015, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245459	A. Building B. Wing	4/7/2015

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	03/12/2015	ID Prefix F0226 Reg. # 483.13(c) LSC	03/12/2015	ID Prefix F0241 Reg. # 483.15(a) LSC	03/12/2015
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	03/12/2015	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	03/12/2015	ID Prefix F0314 Reg. # 483.25(c) LSC	03/12/2015
ID Prefix F0323 Reg. # 483.25(h) LSC	03/12/2015	ID Prefix F0353 Reg. # 483.30(a) LSC	03/12/2015	ID Prefix F0356 Reg. # 483.30(e) LSC	03/12/2015
ID Prefix F0373 Reg. # 483.35(h) LSC	03/12/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	04/17/2015	33925	04/07/2015
CMS RO				

Followup to Survey Completed on: 2/12/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245459	A. Building / B. Wing: 01 - MAIN BUILDING 01	4/17/2015

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed
ID Prefix: Reg. # NFPA 101 LSC K0147	03/04/2015

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/KJ	04/17/2015	34764	04/07/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/10/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES | CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 0K4H
Facility ID: 00352

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245459**

2. STATE VENDOR OR MEDICAID NO. (L2) **787477100**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY WINSTED**
(L4) **551 FOURTH STREET NORTH**
(L5) **WINSTED, MN** (L6) **55395**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **02/01/2011**

6. DATE OF SURVEY **02/12/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **65** (L18)

13. Total Certified Beds **65** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Carol Bode, HFE NE II 03/19/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 04/15/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **04/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00320** (L31)

30. REMARKS
Posted 04/15/2015 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 1314
March 4, 2015

Ms. Terry Rieck, Administrator
Benedictine Living Community Winsted
551 Fourth Street North
Winsted, Minnesota 55395-0750

RE: Project Number S5459025

Dear Ms. Rieck:

On February 12, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6**

months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 24, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 24, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the

deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC 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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction

occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 May 12, 2015 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 12, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

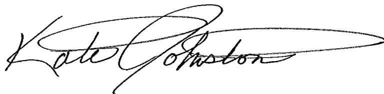
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

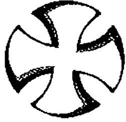
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992   Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File



ST. MARY'S CARE CENTER
Benedictine Health System

Addendum to Plan of Correction

F225 All reports of alleged abuse or resident concerns are brought forward by the Social Worker (or whoever received the complaint) at the daily morning manager's meetings. All concerns are entered electronically and reviewed by the Administrator and/or the DON or the Social Worker for follow up. Any concerns that are questionable are reported to the DOH.

F226- Refer to F225

F314- Results of the audits will be reported monthly to the QAA Committee for further review and/or follow up with continuation or termination of audits recommended at that time.

F323- Results of the audits will be reported monthly to the QAA Committee for further review and/or follow up with continuation or termination of audits recommended at that time.

F353- Results of the audits will be reported monthly to the QAA Committee for further review and/or follow up with continuation or termination of audits recommended at that time.

F356 Charge nurse on weekends will be responsible for the daily posting of nursing hours and census and updating as census and/or staffing changes during his/her shift.

Signed Administrator [signature]

Date 3/19/15

3/19/15 See addendum

PH 320-485-2151
FX 320-485-4241

551 4TH STREET NORTH
SUITE 101
WINSTED, MN 55395

WWW.STMARYSCARECENTER.ORG

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING ____ B. WING ____	02/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	**551 FOURTH STREET NORTH WINSTED, MN 55395**

(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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance.	F 000	RECEIVED MAR 16 2015 MN Dept of Health St.Cloud	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225 3/19/15 See addendum	**F 225** The facility does ensures that all alleged violations involving mistreatment, neglect or abuse, including injuries are reported immediately to the administrator of the facility and other officials in accordance with state laws through established procedures. The facility does have evidence that all alleged violations are thoroughly investigated. The facility does ensure that results of all investigations are reported to the administrator or her designated representative and other officials in accordance with state laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/16/15

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 225	Continued From page 1 representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to immediately report allegations of abuse, neglect to the administrator and state agency; then failed to investigate these allegations for 1 of 3 residents (R3) whose allegations were reviewed. Findings include: R3's annual Minimum Data Set (MDS), dated 11/30/14, indicated R3 had intact cognition, and required extensive assistance with bed mobility and transfers. During interview on 2/9/15, at 6:09 p.m. R3 stated an unknown nursing assistant (NA) had been rough when transferring her out of bed approximately one month prior. The NA swung her legs out of the bed, and struck them on the dresser next to the bed, and told her, "Come on old lady, get out of bed." R3 stated she felt this was abusive, and told the staff about her concerns, "They all knew about it." R3's Musculoskeletal Events report, dated 12/15/14, identified R3 had developed pain and redness to her medial right knee as a result of, "...being assisted from lying to sitting position." The report lacked any indication if the incident	F 225	Upon notification of resident R3 experiencing pain the ADON did interview the resident at the time of the incident of pain being experienced the resident then stated "It happened with the moving of me in bed that morning" She stated "I am always stiff in the morning, I went to swing my legs over the bed and something popped". ADON asked "Did the NAR assist"? R3 stated " Well yes they have to I can't do it by myself. " At the time of the incident or later, no comments were made that she had had been mistreated by an NAR. The DON interviewed her at a later date, and again no comment was made about an NAR	

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F 225	Continued From page 2 was reported to the administrator or state agency, or if any investigation had been completed for alleged abuse and mistreatment. R3's progress note, dated 12/15/14, indicated, "Resident stated that yesterday AM she heard a crack from right knee (affected leg) [secondary to stroke years prior] when NAR [nursing assistant, registered] assisted her from a lying to sitting position...has had pain since..." The note lacked any indication if the incident was reported immediately to the administrator and state agency, nor was the allegation thoroughly investigated as potential abuse. During interview on 2/11/15, at 12:10 p.m. NA-A stated R3 had mentioned someone had been rough getting her up from bed approximately two months ago, and she told the nurse working about it. Further, NA-A thought an investigation had been completed regarding the concerns. When interviewed on 2/11/15, at 12:27 p.m. licensed practical nurse (LPN) -B stated she was aware of a situation regarding R3 and her legs being transferred poorly, but was not involved with it. As a result of the incident R3 now required two people present to assist with transfers. During interview on 2/11/15, at 12:51 p.m. the licensed social worker (LSW)-A stated she was made aware of the incident regarding R3's knee being struck when transferred upon her return from a leave of absence. The former director of nursing (DON) and administrator were in charge of handling abuse allegations in her absence. They completed training with the nursing staff of how to transfer R3 as a result of the incident, but	F 225	mistreating her or saying rude things to her. She only commented "Things like that happen, I am old you know and laughed." LSW interviewed her on 2/28/2015. She related that she "was having no pain in the knee, no concerns at that time. MD also addressed pain with resident and resident stated "No pain or concerns". LSW will continue to interview this resident 2x month for the next 6 months. Interview questions will be based on dignity, call lights , care issues. Vulnerable Adult policies and procedures have been reviewed with notification to the Administrator and other officials as appropriate. All staff have received training and in-servicing on March 4,5, 2015 New hires will be trained at time of hire.	

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F 225	Continued From page 3 it had not been reported to the state agency or investigated for possible abuse. Further, LSW-A stated this allegation should have been reported to the state agency and investigated as an allegation of abuse. When interviewed on 2/11/15, at 1:03 p.m. the current DON stated R3 had complained about some knee pain on 12/15/14. She thought it occurred when a NA pulled her leg too far over in bed and was going to fast with her, and the incident was not investigated as possible abuse. Further, the DON stated she did not feel the incident was possible abuse, "I do not." During a subsequent interview on 2/12/15, at 8:26 a.m. the DON stated the incident for R3 was not reported to the administrator. A facility Abuse Prevention Plan policy, dated 8/22/13, indicated objectives of, "Protect vulnerable adults cared for at our facility from maltreatment", and, "To encourage reporting of suspected maltreatment." The policy directed staff to, "...report the information to their supervisor. The supervisor in turn must immediately (bolded print) report all suspected maltreatment to the Administrator." Further, the policy directed staff to then immediately report to the state agency, and, "The Administrator, Director of Nursing / Designee (Others as identified) are responsible for immediate review, investigation and reporting all suspected cases of maltreatment." The facility administrator was off campus, and unavailable for interview during the survey.	F 225	Witness investigation forms and checklists are currently in use for all investigations. Clinical Nurses and Supervisors, LSW, DON have been in-serviced on investigative procedures and reporting to Administrator. Administrator and DON will document according to VA policy and procedures and their notification of the alleged violation and the dates to which the matter was resolved as well as maintaining tracking logs. LSW/Designee will interview 2 residents/families per week x 2 months, then 1 per week times 4 months. LSW to maintain files and investigative logs and report to QAA on a monthly basis. Administrator will monitor this process for on-going compliance. Corrected date 3-12-2015	3/12/15
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

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F 226	Continued From page 4 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to implement policies to ensure allegations of abuse were immediately reported to the administrator and state agency, then thoroughly investigated for 1 of 3 residents (R3) whose allegations were reviewed. Findings include: A facility Abuse Prevention Plan policy, dated 8/22/13, indicated objectives of, "Protect vulnerable adults cared for at our facility from maltreatment", and, "To encourage reporting of suspected maltreatment." The policy directed staff to, "...report the information to their supervisor. The supervisor in turn must immediately (bolded print) report all suspected maltreatment to the Administrator." Further, the policy directed staff to then immediately report to the state agency, and, "The Administrator, Director of Nursing / Designee (Others as identified) are responsible for immediate review, investigation and reporting all suspected cases of maltreatment." R3's annual Minimum Data Set (MDS), dated 11/30/14, indicated R3 had intact cognition, and required extensive assistance with bed mobility and transfers.	F 226	**F226** The facility has implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. The facility's policy has been modified to reflect the immediate report of any suspected mistreatment or abuse and investigative logs have been set ups and will be maintained by the LSW. The policy is updated to reflect the clear identification of what is to be reported to the Administrator and this policy is updated to reflect appropriate officials to include in the investigative procedure.	

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F 226	Continued From page 5 During interview on 2/9/15, at 6:09 p.m. R3 stated a nursing assistant (NA) had been rough when transferring her out of bed approximately one month prior. The NA swung her legs out of the bed, and struck them on the dresser next to the bed, and told her, "Come on old lady, get out of bed." R3 stated she felt this was abusive, and told the staff about her concerns, "They all knew about it." R3's progress note, dated 12/15/14, indicated, "Resident stated that yesterday AM she heard a crack from right knee (affected leg) [secondary to stroke years prior] when NAR [nursing assistant, registered] assisted her from a lying to sitting position...has had pain since..." The note lacked any indication if the incident was reported immediately to the administrator and state agency, nor was the allegation thoroughly investigated as potential abuse. During interview on 2/11/15, at 12:51 p.m. the licensed social worker (LSW)-A stated she was made aware of the incident regarding R3's knee being struck when transferred upon her return from a leave of absence, and the former director of nursing (DON) and administrator were in charge of handling abuse allegations in her absence. Training had been completed with the nursing staff regarding how to transfer R3 as a result of the incident, but it had not been reported to the state agency or thoroughly investigated for potential maltreatment. Further, LSW-A stated it should have been reported to the state agency and investigated according to their policy, "If we are going from our policy." When interviewed on 2/11/15, at 1:03 p.m. the	F 226	This will include any areas of Physical Abuse, Sexual Abuse, Emotional Abuse, Mental Abuse, Psychological Abuse, or Verbal Abuse, Involuntary Seclusion, Neglect, Exploitation or Misappropriation of resident property, Catastrophic Reaction and Resident to Resident altercations. This training was in-serviced March 4 and 5, 2015. It will be repeated as needed to include all shifts and employees. It will be done annually thereafter and all new hires will receive this training at time of hire.	3/5/15

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F 226	Continued From page 6 current DON stated R3 had complained about some knee pain on 12/15/14. She thought it occurred when a NA pulled her leg too far over in bed and was going to fast with her, and the incident was not investigated as possible abuse. Further, the DON stated she did not feel the incident was possible abuse, "I do not." During a subsequent interview on 2/12/15, at 8:26 a.m. the DON stated the incident for R3 was not reported to the administrator. The facility administrator was off campus, and unavailable for interview during the survey.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with transferring and eating in a dignified manner for 1 of 3 residents (R25) who were dependent upon staff for activities of daily living. Findings include: R25's quarterly Minimum Data Set (MDS) dated 12/25/14, identified diagnoses of dementia, and Alzheimer disease. The MDS also indicated R25 had severe cognitive impairment and required extensive assistance for eating, toileting, dressing and transferring.	F 241	**F241** The facility does promote care for residents in a manner and environment that maintains or enhances each residents dignity and respect in full recognition of his or her individuality. Facility Policies and Procedures on "Quality of Life " including treating our residents with dignity and respect has been in-serviced on March 12, 2015. New hires will be oriented to these policies and procedures at time of hire.	

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F 241	Continued From page 7 During observation on 02/11/2015 on 8:42 a.m., nursing assistant (NA)-B and NA-C entered the residents room to assist her with personal cares. NA-B talked to R25, got a wash cloth and washed R3's face. Both NA's assisted R25 to a sitting position and put on her pants and foot wear. They put her feet on the EZ stand, placed the lift strap around her and assisted her to a standing position with the mechanical lift with her pants around her knee. Both NA's proceeded to roll the mechanical lift around the bed and into the bathroom while R25's pants were around her knee area exposing her brief. While R25 was being rolled into the bathroom in the lift, R25 started to loudly and frantically yell out, "I'm falling, I'm scared" while being wheeled into the bathroom. Neither NA responded to R25's yelling out. NA-C stated we normally roll them [the residents] into the bathroom with the EZ stand. NA-B and NA-C washed R25 in the bathroom, changed her brief and pulled up her pants in the bathroom while R25 remained standing in the mechanical lift. R25 was then rolled back into the room and placed her in her wheelchair. During observation on 2/11/2014 at 9:15 a.m. NA-B wheeled R25 in her wheelchair to the day room for breakfast. NA-B got a cup of coffee, water and yogurt and placed these items near R25. NA-B left the area to assist another NA. At 9:26 a.m. R25 attempted to reach for her breakfast but was unable to physically get her coffee, water or yogurt. R25's lips were moving as she attempted to reach for her breakfast. R25 continued to stare at her breakfast, and move her mouth but was unable to reach her breakfast or eat independently. During this time a universal worker (UW)-B was sitting at R25's table but	F 241	Resident 25 is being monitored on-going for compliance to receiving prompt feeding at meals. Intakes being recorded timely. A commode is at bedside for her use at this time. Clinical Manager responsible for compliance. To ensure dignity with transfers licensed nurses to observe one transfer per week x 3 months. Clinical managers/DON to ensure compliance. Clinical Managers, Supervisors, LSW/TR will monitor through interviewing and observing compliance to these policies and procedures for all residents LSW/TR to do 2 interviews per week for the next 8 weeks then 1 interviews per week for 4 months. DON/Designee available at meal time to assure compliance 3x weekly. Audits to be reviewed at QAA for further follow up if needed.	Corrected date 3—12-2015

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F 241	Continued From page 8 made no attempts to offer or assisted R25 to eat her breakfast. At 9:29 a.m. the activity director (AD)-A asked R25 if she wanted something to drink and assisted R25 to take a sip of water. AD-A asked R25 if she was hungry, R25 replied, "Yes." AD-A opened the yogurt, placed the yogurt in front of R25 and left the area. UW-B continued to sit at the table and watch R25. Neither the UW-B or AD-A assisted R25 to eat her breakfast. At 9:35 a.m. the UW-B left the table where R25 was sitting. During interview 9:35 a.m. UW-B stated her role was to make beds, pass ice water and feed residents. When asked about assisting R25 to eat, UW-B stated she was told not to feed residents when the surveyors were in the building, so she did not assist R25. R25 continued to sit waiting for assistance in the dining room until 9:55 a.m. when an unidentified activiy assistant removed R25 from the dining room and brought her to church. R25 remained in the dining room from 9:15 a.m. until 9:55 a.m., a total of 40 minutes without any assistance to eat her breakfast. The above observations were discussed on 02/11/2015 at 1:28 p.m. with registered nurse (RN)-A. RN-A agreed rolling R25 around the room on the EZ lift with her pants down and not assisting R25 after putting food in front of her were dignity concerns. RN-A stated she would get a commode in R25's room to avoid the situation. During interview on 02/12/2015, at 11:02 a.m. AD-A stated placing food in front of a dependant resident, and not providing assistance to eat it would be a dignity concern for any resident. During an interview on 02/12/2015, at 10:09 a.m.	F 241	DON/Administrator responsible for compliance to policies and procedures being followed. Corrected 3-12-15	3/12/15

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F 241	Continued From page 9 the director of nursing (DON) stated she had no dignity concerns for how R25's care had been provided. A facility dignity policy was requested, but not received.	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not ensure care planned interventions were followed by staff for 1 of 3 residents (R3) who needed assistance for repositioning and for 1 of 1 residents (R82) who had restorative nursing. Findings include: REPOSITIONING: R3's annual MDS, dated 11/30/14, identified R3 had intact cognition, required extensive assistance with bed mobility and transfers, and was at risk for pressure ulcer development. R3's care plan, dated 1/14/15, indicated R3 had potential for impaired skin integrity, and listed a goal of, "Resident's skin will remain intact this quarter; no pressure ulcers." The care plan identified an intervention of, "Turn and reposition Q2H [every 2 hours] when in bed and w/c	F 282	**F282** The services provided or arranged by St. Mary's Care Center must be provided by qualified persons in accordance with their plan of care. R3 care plan and nursing assistant's care sheets have been reviewed with Clinical Managers, Supervisors and all nursing personal. Audits are in place and being completed that she is turned and re-positioned timely. Audits are done 2x weekly for 3 weeks. Clinical Manager responsible for compliance to turning and repositioning schedule is being followed. R82 care plan and nursing assistant's care sheet reflect an on-going need for restorative nursing and an Ambulation Program. Nursing staff in-serviced to	

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F 282	Continued From page 10 [wheelchair]." During continuous observation on 2/11/15, at 6:36 a.m. R3 was assisted with morning cares by nursing assistant (NA)-A and NA-D and at 6:48 a.m. R3 was transferred into her wheelchair. R3 remained in her wheelchair watching television and listened to a portable radio in her room, then self propelled to the facility dining room for breakfast at 7:40 a.m. At 8:17 a.m. she returned to her room to watch television. The facility beautician knocked and entered R3's room at 9:04 a.m. and trained medication aide (TMA)-A entered and provided medication to R3 shortly after, but did not offer R3 to reposition. R3 left her room, and self propelled to the beauty shop at 9:07 a.m., remaining seated in her wheelchair, in the beauty shop until 9:34 a.m. R3 remained in her wheelchair, from 6:48 a.m. to 9:34 a.m. without being repositioning for 2 hours and 44 minutes. During interview on 2/11/15, at 9:41 a.m. NA-A stated R3 was unable to reposition herself, and the care sheet directed staff to reposition her every two hours. When interviewed on 2/11/15, at 9:54 a.m. LPN-A stated a residents care plan drives their care, and it is important they are followed. R3 should have been assisted to reposition in her wheelchair every two hours. RESTORATIVE NURSING: R82's admission Minimum Data Set (MDS), dated 12/17/14, indicated intact cognition and diagnoses including rehabilitation procedures	F 282	policies and procedures on "Restorative Programs" licensed staff in-serviced to the audit system by March 12, 2015. 2 Audits weekly for 4 weeks then 1 audit weekly for three months. Being completed daily at this time for compliance for one week Nursing staff in-serviced March 10, 2015 to the correlation of the NAR Assisgnment Sheets and the Care Plan and how the NAR assignment sheet is derived from the Care Plan. Clinical managers are auditing that approaches on the care plan are on the assignment sheets and are being carried through. Audits will be completed 3x week for 6 weeks. Audits will be conducted for other residents to ensure that care plan interventions are followed. Audits 2 per week times 4 weeks then 1 per week x four months.	

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BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

(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 282	Continued From page 11 NEC (not elsewhere classified), and gait abnormality. The MDS further indicated R82 required extensive assistance with ambulation and limited assistance of one for transfers. The care plan, updated 1/13/15, indicated R82 had potential for falls due to impaired balance and history of falls at home. The care plan also indicated the following interventions, "Walking Program", and "Assist of one and FWW for transfers and ambulation." A restorative nursing order, dated 1/13/15, indicated R82 was to ambulate 50 feet with gait belt and front wheeled walker (FWW) with wheelchair to follow BID (twice per day). During observation on 2/12/15, at 9:02 a.m. R82 was in his room seated in a recliner with his feet up watching television. R82's call light, wheelchair, and walker were placed near him and made no attempts to ambulate. During interview on 2/11/15, at 2:06 p.m. NA-H stated restorative programs and range of motion are not being completed. R82's Restorative Flowsheet from 1/13/15-1/31/15 indicated R82 was ambulated one time per day on 1/14/15 and 1/31/15. All other dates for the month of January 2015 were incomplete. Review of the Restorative Flowsheet from 2/1/15-2/12/15 indicated that R82 ambulated one time on 2/4/15 and one time on 2/5/15. On 2/6/15 and 2/11/15, the documentation indicated R82 was too unsteady on his feet to ambulate. All other dates for February 2015 were missing. During an interview on 2/12/15, at 3:44 p.m. nursing assistant (NA)-E stated "The nursing	F 282	Clinical Managers responsible for the compliance of this program. Review of audits to be completed at QAA on a monthly basis. Corrected date 3-12-2015 DON to ensure compliance to policy and procedures by nursing personnel.	

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F 282	Continued From page 12 assistants are responsible for completing restorative nursing." NA-E also stated, "As the restorative nursing is completed, we must document it in the restorative nursing books" that are kept in the north wing nursing office. When interviewed on 2/12/15, at 3:51 p.m. RN-C stated, "If the restorative nursing is not documented, it has not been done." She also stated, "I expect staff to complete and document restorative nursing." RN-C said, if staff were unable to get the restorative nursing done, they should be notifying me. During interview on 2/11/15, at 2:08 p.m. the DON stated care plans are not used to make nursing assignments, and did not think the NA staff even knew what they were, "It is not information they need to have." A facility policy on care planning was requested, but not provided.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 provide assistance with eating for 1 of 3 residents (R25) who was dependent on staff for eating, and failed to	F 312	**F312** St. Mary's Care Center residents that are unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, personal and oral hygiene.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 312	Continued From page 13 implement restorative ambulation services for 1 of 2 residents (R82) who needed extensive staff assistance with ambulation. Findings include: R25's quarterly Minimum Data Set (MDS) dated 12/25/14, indicated R25 had diagnoses of dementia, Alzheimer disease and depression. She had severe cognitive impairment and required extensive assistance with eating. During observation on 2/11/2014 at 9:15 a.m. NA-B wheeled R25 in her wheelchair to the day room for breakfast. NA-B got a cup of coffee, water and yogurt and placed these items near R25. NA-B left the area to assist another NA. At 9:26 a.m. R25 attempted to reach for her breakfast but was unable to physically get her coffee, water or yogurt. R25's lips were moving as she attempted to reach for her breakfast. R25 continued to stare at her breakfast, and move her mouth but was unable to reach her breakfast or eat independently. During this time a universal worker (UW)-B was sitting at R25's table but made no attempts to offer or assisted R25 to eat her breakfast. At 9:29 a.m. the activity director (AD)-A asked R25 if she wanted something to drink and assisted R25 to take a sip of water. AD-A asked R25 if she was hungry, R25 replied, "Yes." AD-A opened the yogurt, placed the yogurt in front of R25 and left the area. UW-B continued to sit at the table and watch R25. Neither the UW-B or AD-A assisted R25 to eat her breakfast. At 9:35 a.m. the UW-B left the table where R25 was sitting. During interview 9:35 a.m. UW-B stated her role was to make beds, pass ice water and feed residents. When asked about assisting R25 to eat, UW-B stated she was told not to feed	F 312	R25 This resident will receive assist with eating in a timely manner. Nursing staffwill be in the dining room/resident's room and ensure that this resident will receive and be assisted with dietary needs on an on-going basis. Clinical Managers and Supervisors responsible for compliance. R82 this resident will receive his" Restorative Programming" on an on-going basis. Licensed nurses to ensure compliance by daily audits. Clinical Managers, Supervisors responsible to policies and procedures.Nursing personal in-serviced to these policies and procedures March 12, 2015. Audits to be completed daily by licensed personal x one week and interviews will be conducted by DON for compliance with programs.	

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F 312	Continued From page 14 residents when the surveyors were in the building, so she did not assist R25. R25 continued to sit waiting for assistance in the dining room until 9:55 a.m. when an unidentified activity assistance removed R25 from the dining room and brought her to church. R25 remained in the dining room from 9:15 a.m. until 9:55 a.m., a total of 40 minutes without any assistance to eat her breakfast. During an interview on 02/11/2015 at 1:28 p.m. registered nurse (RN)-A stated R25 was typically fed by staff and this should have been done. An interview on 02/12/2015 at 11:02 a.m. with AD-A said someone should have fed R25. R82's admission Minimum Data Set (MDS), dated 12/17/14, indicated intact cognition and diagnoses including rehabilitation procedures NEC (not elsewhere classified), symptoms of gait abnormality. The MDS further indicated R82 required extensive assistance with ambulation and limited assistance of one for transfers. The care plan, updated 1/13/15, identified R82 had a restorative ambulation program. A restorative nursing order, dated 1/13/15, indicated R82 was to ambulate 50 feet with a gait belt and front wheeled walker (FWW) with wheelchair to follow BID (twice per day). During observation on 2/12/15, at 9:02 a.m. R82 was in his room seated in a recliner with his feet up watching television. R82's call light, wheelchair, and walker were placed near him. R82 made no attempts to use his walker and ambulate.	F 312	Restorative Programs for other residents will be audited by clinical Managers for compliance to procedures being completed 2 x weekly for one month then 1 x weekly for 4 months. DON to interview 2 residents per week x 3 months and audit restorative records weekly x 4 months. Report to QAA on a monthly basis compliance to programs. Corrected Date 3-12-2015	3/12/15

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F 312	Continued From page 15	F 312		

Review of R82's Restorative Flowsheet from 1/13/15-1/31/15 identified R82 was ambulated one time per day on 1/14/15 and 1/31/15. All other dates for the month of January 2015 were incomplete. Review of the Restorative Flowsheet from 2/1/15-2/12/15 indicated that R82 ambulated one time on 2/4/15 and one time on 2/5/15. On 2/6/15 and 2/11/15 the documentation indicated R82 was too unsteady on his feet to ambulate. All other dates for February 2015 were left blank.

The facility Physical Therapy Discharge Summary, dated 1/2/15, indicated R82 was discharged from skilled PT (physical therapy) with recommendations for transfers and walking, with assist of one with use of FWW, regular range of motion (ROM), and strengthening exercises with wellness, and regular mobility to maximize R82's functional activity independence.

During interview on 2/11/15, at 2:06 p.m. NA-H stated restorative programs and range of motion are not being completed.

During an interview on 2/12/15, at 3:44 p.m. nursing assistant (NA)-E stated "The nursing assistants are responsible for completing restorative nursing." NA-E also stated, "As the restorative nursing is completed, we must document it in the restorative nursing books" that are kept in the north wing nursing office.

In an interview on 2/12/15, at 3:49 p.m. registered nurse (RN)-B stated, "The NA's document the restorative nursing as they complete it." It is the NA's responsibility to complete and document restorative nursing programs.

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F 312	Continued From page 16 When interviewed on 2/12/15, at 3:51 p.m. RN-C stated, "If the restorative nursing is not documented, it has not been done." She also stated, "I expect staff to complete and document restorative nursing." If staff were unable to get the restorative nursing completed, they should be notifying me. A facility policy on restorative nursing was requested, but not provided.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely repositioning to reduce the risk or pressure ulcer formation for 1 of 3 residents (R3) reviewed for pressure ulcers. Findings include: R3's annual Minimum Data Set (MDS), dated 11/30/14, indicated R3 had intact cognition, required extensive assistance with transfers, bed mobility, and was at risk for pressure ulcer	F 314	**F314** St. Mary's Care Center does ensure that a resident who enters our facility without a pressure sore does not develop a pressure sore unless the individuals condition demonstrates that they were unavoidable and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from happening R3 will be offered turning and re-positioning per her plan of care and NAR assignment sheet. Licensed nurses are doing audits, these are performed 2x week for 3 weeks to ensure these policies and procedures are being carried through for one month.	

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F 314	Continued From page 17 development. R3's Skin Risk Assessment, dated 1/17/15, indicated R3 had no current pressure ulcers, and required two assist with transfers, and turning and repositioning. Further, R3 was considered, "AT RISK" for pressure ulcer formation, and identified, "Resident is turned and repositioned q2h [every two hours]." R3's care plan, dated 1/14/15, indicated R3 had potential for impaired skin integrity, and listed a goal of, "Resident's skin will remain intact this quarter; no pressure ulcers." The care plan identified an intervention of, "Turn and reposition Q2H when in bed and w/c [wheelchair]." R3's pressure ulcers Care Area Assessment (CAA), dated 12/12/14, indicated R3 was at risk for pressure ulcers related to needing assistance with mobility, and identified R3 should be, "Off loaded in WC [wheelchair] every two hours and PRN [as needed]." During continuous observation on 2/11/15, at 6:36 a.m. R3 was assisted with morning cares by nursing assistant (NA)-A and NA-D, and assisted to sit in her wheelchair at 6:48 a.m.. R3 watched television (TV) and listened to a portable radio in her room, then self propelled to the facility dining room for breakfast at 7:40 a.m.. She returned to her room at 8:17 a.m. and resumed to watch TV. The facility beautician knocked and entered R3's room at 9:04 a.m. and trained medication aide (TMA)-A entered and provided medication to R3 shortly after, but made no attempts nor offered R3 to reposition. R3 left her room, and self propelled in her wheelchair to the beauty shop at 9:07 a.m., and remained in the beauty shop until	F 314	Nursing staff in-serviced to policies and procedures on pressure ulcer prevention and the importance of turning and positioning. Also on the importance of following Care Plans and NAR Assignment sheets. Licensed nurses to audit daily x 1 month, 3x week for 1 month, 1x week for one month and Clinical Managers to ensure compliance. DON responsible for compliance to this system. Corrected Date 3-12-2015	

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F 314	Continued From page 18	F 314		

9:34 a.m. when the observation was ceased, and NA-A was notifed by the surveyor that R3 had not beed repositioned. When interviewed on 2/11/15, at 9:41 a.m. NA-A stated R3 was unable to reposition herself, but staff were only helping her to reposition when she needed assistance using the restroom two to three times a day. Further, NA-A stated R3's care sheet identify (R3) should be assisted with repositioning every two hours. Although R3's care plan identified R3 was at risk for pressure ulcer development, she remained in her wheelchair, from 6:48 a.m. until 9:34 a.m., 2 hours and 44 minutes without any assistance by staff for repositioning.

During interview on 2/11/15, at 9:54 a.m. licensed practical nurse (LPN)-A stated R3 was at risk for pressure ulcer development, and should have been repositioned every two hours as directed in her care plan.

When interviewed on 2/11/15, at 1:18 p.m. registered nurse (RN)-A stated R3 should be offered, and assisted to reposition every two hours when seated in her wheelchair because of her risk of developing pressure ulcers.

During interview on 2/11/15, at 2:08 p.m. the director of nursing (DON) stated R3 was at risk for pressure ulcer development, and should have been offered repositioning every two hours as directed by the care plan.

A facility Pressure Ulcer Policy, dated 6/2014, indicated a policy of assuring, "The care plan clearly reflects the resident's skin condition, goals and approaches to be used." Further, preventative measures listed included, "Repositioning schedules and/or ROM therapy."

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 4 residents (R3) observed during transfers was assessed for safe transfers using an EZ Stand brand machine (mechanical device that uses a sling to stand someone) with a Volaro brand sling, which the EZ Stand manufacturer had not recommended for use. Findings include: R3's annual Minimum Data Set (MDS), dated 11/30/14, indicated R3 had intact cognition, and required extensive assistance with transfers and bed mobility. During observation of morning care on 2/11/15, at 6:36 a.m., nursing assistant (NA)-A and NA-D assisted R3 to sit on the bedside, and maneuvered a EZ Stand machine in front of R3. NA-A and NA-D secured a blue Volaro sling behind R3, and attached it to the EZ Stand machine, assisting R3 to stand up and transfer to her wheelchair. NA-D placed the blue Volaro sling on the machine, and moved it into the hallway outside R3's room for other resident to	F 323	Our facility does ensure that our resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. R3 sling has been changed out to an e-z stand lift sling. A system has been implemented to labels which slings belong with each of our lifts. Audits are completed by environmental services 2x week x 1 month then weekly for 6 months to ensure that the right slings are being used with the right lifts. Licensed nurses observe one lift per week x 3 months to audit that correct sling is with correct lift. DON/Clinical managers/Administrator monitor for compliance. This system has been in-serviced to appropriate personal on March 4 and 5, 2015. Administrator responsible for compliance to this system.	Corrected Date 3-12-2015

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F 323	Continued From page 20 use. The sling had a label stitched to it reading, "VOLARO SMT HEALTH SYSTEMS." During interview on 2/11/15, at 9:41 a.m. NA-A stated staff were using the Volaro sling because the EZ Stand slings had broken several days prior, and it would no longer clip to the machine. When interviewed on 2/11/15, at 9:54 a.m. licensed practical nurse (LPN)-A stated she was unaware of the EZ Stand sling was broken, or that staff were using a Volaro brand sling with the EZ Stand machine to transfer residents. Further, LPN-A stated transferring residents using equipment that was not recommended would be a safety hazard, and was unaware if any assessment had been completed to ensure residents were safe to transfer using equipment from different manufacturers. During interview with the environmental service director (ESD), on 2/11/15 at 1:43 p.m., stated the broken EZ Stand sling had been removed from service, and back-up slings were available for staff use in the basement of the facility. Further, ESD stated an EZ Stand sling should have been acquired to transfer residents. When interviewed on 2/11/15, at 2:08 p.m. the director of nursing (DON) stated no assessments had been completed to ensure residents were safe to use a Volaro sling with the EZ Stand machine, but she did not feel it was a safety concern. A facility supplied SMT Health Systems (the manufacturer of Volaro products) memo, dated 2/11/15, indicated, "Should you find the need to use a patient lift and or sling that is not designed	F 323		

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F 323	Continued From page 21 and manufactured by SMT, be aware of the following standards", and identified a standard of, "Always consult your product manuals before use." A EZ Way Stand Operator's Instruction manual, dated 3/11/09, identified slings from other company's should not be used with their machines, "EZ Way harnesses are made specifically for EZ Way stands. For the safety of the patient and caregiver, only EZ Way harnesses should be used with EZ Way stands."	F 323		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353	**F353** St. Mary's Care Center does have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual care plans. R3 is being re-positioned per care plan and NAR Assignment sheet. System implemented to assure compliance on 3-01-2015. Audits being completed for compliance.	

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BENEDICTINE LIVING COMMUNITY WINSTED	**551 FOURTH STREET NORTH WINSTED, MN 55395**

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F 353	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate staffing to ensure residents received the required assistance for 1 of 3 residents (R3) reviewed for pressure ulcers, 1 of 3 residents (R25) reviewed for activities of daily living, and 1 of 3 residents (R82) reviewed for restorative nursing. In addition, for 7 of 22 residents (R66, R15, R112, R11, R44, R54 and R24), and 2 of 3 family members (FM-B, FM-C) interviewed who complained of not receiving timely assistance and 7 of 10 staff members (LPN-A, NA-A, NA-B, NA-J, NA-H, NA-G, and NA-F) interviewed who complained about not being able to complete their assigned job duties related to insufficient staffing. Findings include: ASSESSED NEEDS NOT BEING COMPLETED FOR RESIDENTS: Refer to F282; The facility did not ensure care planned interventions for repositioning were followed for 1 of 3 residents (R3) reviewed for pressure ulcers, failed to ensure assistance with eating was provided to 1 of 3 residents (R25) reviewed who needed staff assistance with eating. In addition, the facility did not ensure ambulation programs were completed as directed for 1 of 1 residents (R82) reviewed for restorative nursing. Refer to F312; The facility did not provide assistance with eating for 1 of 3 residents (R25) who was dependent on staff for eating, and failed	F 353	R25 is being assisted with feeding per plan of care and NAR Assignment sheet , audits completed and on-going as of 3-01-2015 R82 is being assisted with his restorative program and is being ambulated. Audits completed and on-going since 3-05-2015. Call lights for R3,R66,R115,R112,R11,R44,R54, R24 are being monitored on a daily basis. LSW/TR to do weekly interviews for 2x a week for 4 weeks with these residents to monitor for compliance. Interview questions have been in-serviced and reviewed with the above personnal, Interview questions: Are you Treated with dignity?, Are call Call lights answered promptly? Do you have any care issues? Adequate staffing to meet your needs?	

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F 353	Continued From page 23 to implement restorative ambulation services for 1 of 2 residents (R82) who needed extensive staff assistance with ambulation. Refer to F314; The facility did not provide timely repositioning to reduce the risk or pressure ulcer formation for 1 of 3 residents (R3) reviewed for pressure ulcers. RESIDENT CONCERNS REGARDING STAFFING: R3's annual Minimum Data Set (MDS), dated 11/30/14, identified R3 had no cognitive impairment, and required extensive assistance with activities of daily living (ADL). During interview on 2/9/15, at 6:15 p.m. R3 stated she has waited up to 30 minutes for her call light to be answered. Further, she has brought her concerns about staffing to the resident council meetings and things had not improved. Review of R3's call light report, dated 2/12/15, identified a total of 98 activations from 1/29/15 to 2/12/15, with 16 occurrences of having to wait over 10 minutes for assistance, 12 times of having to wait over 20 minutes for assistance, and 8 times of having to wait over 30 minutes for help from staff. R3 had 1 occurrence of having to wait over 80 minutes for help from staff according to the report. Review of the facility Resident Council (a group organized by the residents of the facility to present concerns to staff) Minutes, dated 11/2014, identified a concern from the residents regarding having to wait long periods for the call lights to be answered. A later Resident Council	F 353	Reports to Administrator per weekly reviews. Families/Residents will also be interviewed by LSW/TR/DON on an on-going basis. Two times per week for one month then one time per month. Resident/ Family satisfaction surveys will be completed. Call light audits are being completed on a daily basis for one month by the DON for compliance and targeted high frequency times and adjustments are being made to adjust staff breaks and adjust staffing levels to these high frequency times. Staff interviews are being completed by DON one time a week for 3 months. Questions will include: do you feel you have enough time to complete your assignments? What areas are you struggling with? What can we do to help? Administrator responsible for compliance.	Correction 3-12-2015

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Minutes, dated 2/2015, identified additional concerns by residents regarding waiting long periods for the call lights to be answered. An additional document, included with the February 2015 minutes, identified the facility administration was reviewing the staffing concern, but still expected call lights to be answered with 5 minutes.

R66's quarterly MDS, dated 12/29/14, identified R66 had moderate cognitive impairment, and required at least extensive assistance with ADLs. During interview on 2/10/15, at 10:49 a.m. R66 stated she frequently waits for long periods, up to an hour, for staff to help her get ready for bed.

Review of R66's call light report, dated 2/12/15, identified a total of 52 activations from 1/29/15 to 2/12/15. R66 had 13 occurrences of having to wait over 10 minutes for assistance, 7 times of having to wait over 20 minutes for assistance, and 5 times of having to wait over 30 minutes for assistance. R66 had 2 occurrences of having to wait for at least 40 minutes for help from staff according to the report.

R115's admission MDS, dated 1/30/15, identified R115 was cognitively intact, and required extensive assistance with ADLs. When interviewed on 2/10/15, at 9:04 a.m. R115 stated he had waited over 45 minutes to get help while in the bathroom about a week prior, and if he waits too long, he will just transfer himself even though he shouldn't. Further, R115 stated all shifts seemed to be short staffed.

Review of R115's call light report, dated 2/12/15, identified a total of 164 activations from 1/29/15 to 2/12/15. R115 had 24 occurrences of having to

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wait over 10 minutes for assistance, 9 times of having to wait over 20 minutes for assistance, and 4 times of having to wait over 30 minutes for assistance. Further, R115 had 2 occurrences of having to wait for at least 45 minutes for help from staff according to the report.

R112 was interviewed on 2/10/15, at 9:29 a.m. R112 stated she felt the facility was under-staffed, and cited an example of recently having to wait for a long period for staff to assist her. R112 added staff will sometimes be helping her, get called away, and do not finish helping her because they are helping other residents.

Review of R112's call light report, dated 2/12/15, identified a total of 142 activations from 2/6/15 to 2/12/15. R112 had 14 occurrences of having to wait over 10 minutes for assistance, 8 times of having to wait over 20 minutes for assistance, and 2 times of having to wait over 30 minutes for help from staff. R112 had waited a maximum of 45 minutes for assistance according to the report.

R11's quarterly MDS, dated 1/6/15, identified R11 have moderate cognitive impairment, and required at least extensive assistance with ADLs. When interviewed, with FM-E, on 2/10/15, at 10:59 a.m. R11 stated she has waited for almost an hour for help, and often has pain and toileting needs that are not promptly addressed because of having to wait, "We have to wait a long time for help sometimes." Further, FM-E added that staffing concerns had been occurring for an extended period of time, and that they had expressed these concerns to staff before, "They write it down, and that's about it."

Review of R11's call light report, dated 2/12/15,

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identified a total of 309 activations from 1/29/15 to 2/12/15. R11 had 49 occurrences of having to wait over 10 minutes for assistance, 22 times of having to wait over 20 minutes for assistance, and 9 times of having to wait over 30 minutes for help from staff. R11 had waited a maximum of 80 minutes for assistance according to the report.

R44's quarterly MDS, dated 12/8/14, identified R44 was cognitively intact, and required supervision to safely complete her ADLs. During interview on 2/9/15, at 6:40 p.m. R44 stated she has waited for almost 30 minutes for help from staff before, and was worried she could have a low blood sugar or need prompt help and not get it. Further, R44 stated she expressed her concerns to the staff, and has overheard them complaining to each other about being short staffed in the past, "It seems like they are short of help a lot."

Review of R44's call light report, dated 2/12/15, identified a total of 50 activations from 1/29/15 to 2/12/15. R44 had 6 occurrences of having to wait over 10 minutes for assistance, 4 times of having to wait over 20 minutes for assistance, and 2 times of having to wait over 30 minutes for help from staff. R44 had waited a maximum of 39 minutes for assistance according to the report.

R54's quarterly MDS, dated 12/24/14, identified R54 was cognitively intact, and required extensive assistance with ADLs. When interviewed on 2/9/15, at 3:37 p.m. R54 stated the facility needed more staff to help residents, and it often takes over 30 minutes to get help using the bathroom. R54 added, staff have helped her to the bathroom, then not returned to

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help her when she was finished.

Review of R54's call light report, dated 2/12/15, identified a total of 692 activations from 1/29/15 to 2/12/15. R54 had 71 occurrences of having to wait over 10 minutes for assistance, 19 times of having to wait over 20 minutes for assistance, and 8 times of having to wait over 30 minutes for help from staff. R54 had waited a maximum of 49 minutes for assistance according to the report.

R24's quarterly MDS, dated 11/4/14, identified R24 had no cognitive impairment, and required extensive assistance with ADLs. When interviewed on 2/9/15, and 6:10 p.m. R24 stated she finds a couple times a week, that she will have to wait for long periods for help from staff. Further, R24 stated she has transferred herself into a wheelchair before and has went to look for help because of the amount of time it takes to be assisted and was unable to find anyone.

FAMILY CONCERNS REGARDING STAFFING:

When interviewed on 2/9/2015, at 6:15 p.m. family member (FM)-B said he felt frustrated that R50 "just doesn't get to walk as often as she should," because, "the facility just doesn't staff like it should." FM-B said he felt R50 had given up, and that was "frustrating and it hurts me to see her like that." FM-B questioned why R50 "could not get walks more frequently."

During an interview on 2/10/15, at 10:47 a.m., family member (FM)-C stated R12 "too often" had to wait a "long time to use the bathroom, especially on the weekends." FM-C also stated R12 "has had accidents, soiling herself," and

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further that "it could have been prevented." FM-C said "just in general it [facility] seems to be lacking of staff."

STAFF CONCERNS REGARDING STAFFING:

When interviewed on 2/10/15, at 1:09 p.m., licensed practical nurse (LPN)-A stated she was frequently pulled to the floor to help with resident care. Further, the facility had recently had a lot of staff turnover, "We've made a lot of staffing changes lately."

During interview on 2/11/15, at 11:58 a.m. nursing assistant (NA)-A stated the typical staffing for the facility included 1 NA on the rehabilitation unit, 1 NA on the North wing, and 2 NA on the South wing. In addition, there was a nurse and a trained medication aide (TMA) on both the North and South wings. Further, NA staff often struggle to get help from the rest of the facility staff in answering call lights and helping residents, "All depends on who you are working with that day."

When interviewed on 2/11/15, at 1:43 p.m. NA-B stated there were days that were "frankly very demanding, because a lot of the residents require two staff, because of the lifts, as well as the demands with turning and toileting residents." NA-B further stated that while resident safety was not compromised, resident "turning, repositioning and toileting was "postponed." Further, NA-B stated, if there were more staff available for the residents, more one to one time could be provided to the residents, "I would say it is a quality of life issue for the residents."

When interviewed on 2/11/15, at 1:52 p.m. NA-J

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stated that fifty percent of the time she felt she was unable to complete her assigned tasks for the residents, and residents often report having to wait for extended periods of time to have their call lights answered.

During interview on 2/11/15, at 2:06 p.m. NA-H stated residents often complain about have to wait for long periods before being helped. Further, NA-H stated the current staffing was inadequate and restorative programs and range of motion were not being completed as a result.

When interviewed on 2/12/15, at 9:56 a.m. NA-G stated someday's present more work to do then their are workers to complete it, and at times she has left the facility knowing resident tasks did not get completed thoroughly because of the lack of time and staff.

During interview on 2/12/15, at 11:25 a.m. NA-F stated she felt she did not consistently have time to complete all of her assigned work, and residents often have to wait a long time for staff to help them with their needs, "I feel some residents are being neglected and not getting the cares done that they need." Further, call lights are often noted to remain on for long periods of time because staff are unable to promptly answer them.

When interviewed on 2/12/15, at 9:10 a.m. the staffing coordinator (SC) stated she felt the facility had adequate staffing, but could always use more. Further, the facility had no formal staffing policy, but followed a formula (# [number] of residents X [times] 3.59) to create the daily staffing, with acuity being factored in.

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F 353	Continued From page 30 During interview on 2/12/15, at 4:44 p.m. the director of nursing (DON) stated the facility is always looking for new staff, and felt the call lights were sometimes activated by residents who did not really require assistance and could complete the care themselves. The facility administrator was off campus, and unavailable for interview during the survey.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356	F356 The facility will post the nurse staffing data on a daily basis and changes will be made by Licensed personal at the beginning of each shift. Licensed nurses have been in-serviced March 10,2015 to update the daily census and staffing hours at the beginning of each shift and post current data at that time. DON to audit mandated nursing hours daily times 1 week then 3 x a week for three months. DON/Administrator to monitor for compliance. Correction 3-12-2015	3/12/15

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F 356	Continued From page 31 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to correctly display and update the required posting of nursing staff. This had the potential to affect all 55 current residents, as well as family and visitors to the facility. Findings include: During the initial tour or the facility on 2/9/2015 at 1:47 p.m., the staff posting was pinned to a bulletin board on the main floor, between the nursing station and hallway leading to the dining room. The posting was undated, but otherwise indicated a census of 55, and all other required staffing information. During reconciliation in preparation of the facility survey on 2/9/2015 at 2:15 p.m., the director of nursing (DON) said the current facility census was "53 residents." During an interview on 2/11/2015 at 12:29 p.m., the staffing coordinator (SC) stated she put together the staff posting each day, and as of Monday, the 9th, "it was my first day I resumed doing [the posting]" and it "was in a new format." The SC said she realized the mistake of omitting the date on the form, and made the change to include the date on the posting the very next day. During further interview, the SC said the former DON had assumed the task of staff posting "until	F 356		

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F 356	Continued From page 32 she left last Friday," and also, that the postings for Saturdays and Sundays were routinely prepared on Friday. The SC stated she would continue to print, on Fridays, the staff posting sheets to be displayed for the weekend. If there was a change of resident census and or schedule this may not be updated on the weekends. In an interview on 2/11/2015 at 1:00 p.m., the DON said the form was "just changed" since the former DON left last Friday. When questioned if the staff posting was update at daily to reflect changes in census or staffing, "We don't do anything like that right now." The DON stated she was "not aware of any requirement" to update the posting each shift to reflect changes. A facility policy, regarding posting of nurse staffing information, undated, indicated the nursing hours were "posted on a daily basis..." and would reflect the required information, including the current date.	F 356		
F 373 SS=E	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a	F 373	**F373** Eliminated the Paid Feeding Assistant Program as all residents who need to be fed are at risk.	3/16/15

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F 373	Continued From page 33 supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals used by the facility as feeding assistants, who	F 373		

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have successfully completed the training course for paid feeding assistants.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure 1 of 5 residents (R35) who had difficulty swallowing was observed being assisted by a paid feeding assistant (PFA) (non-nursing trained person used to assist resident with eating). In addition, the facility failed to ensure an assessments had been completed to determine if a resident could be safely fed by a PFA for 4 of 5 residents (R25, R1, R45, and R89) who had difficulty swallowing and were identified as being appropriate to be fed by a PFA.

Findings include:

During the entrance conference on 2/9/15, at 1:37 p.m. the director of nursing (DON) stated the facility used universal workers (un-licensed staff, called PFA) which were used to assist residents to eat. The DON stated PFAs could feed any resident who needed help with their meal, and there was no specific criteria being used to determine who was safe to be fed by a PFA.

R35's quarterly Minimum Data Set (MDS), dated 10/30/14, identified severe cognitive impairment, and also that R35 needed extensive assistance with eating, and required a mechanically-altered diet.

R35's Nutritional Assessment, dated 1/27/15, identified R35's diet as "Regular/NDD2 [dysphagia, mechanically altered], pureed PRN

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	245459	A. BUILDING ______ B. WING ______	02/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

(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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[as needed]", and required assistance with feeding. R35's Nutritional Status CAA, dated 8/13/14, identified R35 to be, "totally assisted at meals for eating and drinking and ADL's," and, "has poor dentition and is at risk for having chewing problems." Further, "Will continue to monitor Res. [resident] chewing and swallowing, intakes and weights."

R35's care plan, dated 1/2/15, identified R35 consumed a NDD2 diet with thin liquids, and, "Requires a mechanically altered diet, Diet change to mechanical soft on 12/15/08 r/t [related to] to pocketing and not chewing food." Further, R35 required total feeding assistance.

R35's progress note, dated 1/14/15, identified R35, "Ate 50% of breakfast, slept threw lunch would not arouse to eat, took one sip and let it run out of her mouth..." An additional progress note, dated 12/18/14, identified R35 was seen by speech therapy with a focus on swallowing, "Staff are reporting a decline in patient's ability to chew...has considerable labial and lingual weakness and appears to be safer eating NDD2 diet with thin liquids still OK.

During observation of the lunch meal on 2/11/15, at 11:58 a.m. R35 was seated at a table in the memory care dining room with several other residents. R25 and R45 were being assisted to eat by an unknown nursing assistants (NA), and R35 was being assisted to eat by PFA-B. PFA-B picked up a fork with food, and provide several bites of food to R35. R35 ate, and did not seem to have any problems with swallowing while being fed by PFA-B.

R35's Speech Therapy Plan of Care, dated

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F 373	Continued From page 36 12/18/14, identified R35 had been, "...referred to therapy dur [sic] to reports from staff of swallowing difficulties during meals for the past few weeks." R35 was noted to have a mechanical soft/ground diet, and, "mild to moderate impairment" in swallowing. During interview on 2/12/15, at 3:21 p.m. the speech therapist (ST)-A stated R35's diet was adjusted based on how alert she was during meal times. She still remains at risk for aspiration, and should not be fed by someone who was not well trained. There was no indication in the record that an assessment had been completed to determine if R35 could be safely fed by a PFA, even though she was identified by the ST as having difficulty swallowing during meals since 12/18/14. R25's admission MDS, dated 12/25/14, indicated severe cognitive impairment and that R25 required extensive assistance with eating. The MDS also identified R25 had a mechanically altered diet, and would, "Hold food in mouth/cheeks or residual food in mouth after meals." R25's Nutritional Assessment, dated 2/2/15, identified R25's diet as "NDD1 diet with Nectar thickened liquids," and, "...has some difficulty chewing foods and is spitting out food at meal times." Further, R25 had a diagnosis of Alzheimer's disease and, "...needs 1:1 [one to one] assist from staff r/t [related to] declining condition." R25's care plan, dated 2/2/15, identified R25 had	F 373		

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	245459	A. BUILDING ______ B. WING ______	02/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	**551 FOURTH STREET NORTH WINSTED, MN 55395**

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F 373	Continued From page 37 a self care deficit, and required assistance with feeding and for verbal cues to be given during eating. The care plan lacked any intervention for R25's identified swallowing difficulties. During observation on 2/11/14, at 9:15 a.m. R25 was assisted to the dining room table by NA-B and provided R25 a cup of coffee, water and a un-opened container of yogurt. NA-B did not assist R25 with eating, and left the dining room. R25 attempted to reach out a grab a cup of the provided fluids, but was unable to reach them. PFA-B was seated at the same table as R25, and observed her having difficulty reaching the cups of fluid, and not eating. PFA-B did not assist R25 to eat. At 9:29 a.m., the activities director (AD) asked R25 if she would like a drink, provided a sip of (approximately 15 cc) fluid, opened the yogurt container and placed it back in front of her without helping R25 to eat. PFA-B stood and walked away from R25's table at 9:35 a.m., and R25 remained at the table without assistance to eat until 9:55 a.m. when she was taken to church by staff. When interviewed on 2/11/15, at 9:35 a.m. PFA-B stated her role was to make beds, pass ice water and feed residents. Further, PFA-B stated she did not assist R25 with eating because she had been told not to help feed residents when state surveyors were in the facility. R25's Speech Therapy Plan of Care, dated 12/24/14, identified R25 had an underlying impairment of swallowing, and, "Moderate oral-pharyngeal dysphagia." Further, R25 demonstrated, "Overt s/s [signs and symptoms] of aspiration on thin liquids X1 [coughing]," and, "...needed cues to clear oral cavity."	F 373		

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During interview on 2/12/15, at 3:21 p.m. the speech therapist (ST)-A stated she had seen R25 before for swallowing concerns, and noted R25 has had episodes of emesis with several textures of food. R25 required staff assistance to eat, "She needs to have somebody right with her." ST-A had recommended a video swallow for R25 prior, but it was not completed due to family refusal, "I'm pretty sure she is aspirating."

There was no indication in the record that an assessment had been completed to determine if R25, could be safely fed by a PFA, even though they were identified by the ST as having episodes of emesis with textured food.

R1's quarterly MDS, dated 10/24/14, indicated moderate cognitive impairment, with diagnoses which included cardio-vascular accident (stroke), hemiplegia and dementia. The MDS also indicated R1 had swallowing deficits, had loss of liquids from mouth when eating or drinking, and would cough or choke during meals, or when swallowing medications. The MDS further identified R1 required a mechanically altered diet, and utilized adaptive utensils and plateware when eating.

R1's nutrition assessment, dated 2/3/15, indicated R1 required a pureed diet, with honey-thickened liquids related to a swallowing/chewing deficit, and that R1 needed supervision and cueing to eat. Further, the assessment identified R1's risk factors for dehydration which included diuretic (water pill) use, dysphasia (difficulty with swallowing) and uncontrolled diabetes.

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F 373	Continued From page 39 R1's care plan, updated 1/17/14, addressed nutritional concerns and identified R1's chewing and swallowing difficulties. The care plan directed staff to provide R1 a regular/NDD1 diet (pureed foods) with HTL (honey-thickened liquids), and to assist to feed, due to [R1's] tendency to eat, drink quickly and have choking episodes. In an interview on 2/12/15 at 3:26 p.m. nursing assistant (NA)-I stated she often assisted R1 to eat. NA-A stated R1 "had difficulty swallowing" and has seen R1 aspirate. NA-I was aware of altered texture diet for R1, and that she "...had difficulty swallowing pureed meats in particular." NA-I said R1 could and did feed herself, but that she needed "encouragement to eat," and often had to be fed. In an interview on 2/12/15 at 3:43 p.m., PFA-E stated she "normally fed [R1]." PFA-E stated she could not recall if R1 had aspirated, or choked, but she did have to assist R1 "to help take her cup, or assist her with her fork or spoon." PFA-E also said she was "unaware of any residents" she was not allowed to feed. During interview on 2/12/15, at 3:21 p.m. ST-A stated R1 aspirated on thin and nectar thickened liquids, and was now currently receiving honey thickened liquids. Further, ST-A added, "She shouldn't be fed by a universal worker (PFA) in my opinion." There was no indication in the record that an assessment had been completed to determine if R1, could be safely fed by a PFA even though they were identified by the ST as being having	F 373		

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problems with aspirating on thin and nectar thickened liquids.

R45's annual MDS, dated 12/8/14, identified intact cognition, and that she required extensive assistance with eating, and had a mechanically altered diet. Further, the MDS identified R45 had a "Loss of liquids/solids from mouth when eating or drinking", "Holding food in mouth/cheeks or residual food in mouth after meals," and "Complaints of difficulty or pain with swallowing."

R45's Nutritional Assessment, dated 12/12/14, identified a diet of, "NDD1 puree with thin liquids," and, "Does have difficulties with swallowing r/t senile dementia, tremors and dysphagia." Further, [R45] "Resident has much difficulty feeding self at meals r/t dysphagia and tremors. Res [resident] needs extensive assistance at meals."

The Nutrition Care Area Assessment (CAA), dated 12/22/14, identified R45 had a swallowing problem, and was unable to perform activities of daily living (ADLs) without significant physical assistance. Further, "Res. [resident] has a swallowing problem and is ordered a mechanically altered diet r/t dysphagia."

When interviewed on 2/12/15, at 3:21 p.m. ST-A stated R45 had advanced Parkinson's disease (a disorder of the central nervous system that affects movement), and was a high risk of choking, "It's pretty high."

There was no indication in the record that an assessment had been completed to determine if R45, could be safely fed by a PFA even though

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they were identified by the ST as being at high risk for choking due to advanced Parkinson.

R89's quarterly MDS, dated 12/16/14, identified R89 had severe cognitive impairment, required extensive assistance with eating, and consumed a mechanically altered diet.

R89's Nutritional Assessment, dated 1/26/15, identified R89 had a current diet of, NDD1 Pureed diet with thickened liquids as tolerated," and demonstrated signs and symptoms of possible swallowing disorder including, "Loss of liquids/solids from mouth when eating or drinking", and, "Coughing or choking during meals or when swallowing medications."

R89's Nutritional Status CAA, dated 1/23/15, identified R89 required, "1:1 assist at meals," and, "...is at risk for aspiration pneumonia with previous diagnosis' of this."

R89's care plan, dated 10/8/14, identified R89 had a diagnosis of dementia and required, "A mechanically altered diet with thickened liquids,' and required, "Total assistance with feeding at meals/snacks."

When interviewed on 2/12/15, at 3:21 p.m. ST-A stated R89 has had several occurrences of aspiration pneumonia in the past few months, and aspirates his food and fluids easily. Further, R89 had a video swallow [an evaluation of swallowing function using an X-ray machine] in the past that showed he aspirates on thin liquids.

R89's Speech Therapy Plan of Care, dated 12/30/14, identified R89 had moderate swallowing

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F 373	Continued From page 42 impairment, and consumed a purred diet with nectar thickened liquids. R89 demonstrated, "Swallowing difficulties are caused by muscle weakness and Alzheimer's [sp] dementia." Further, R89 performed compensatory strategies 70% of the time with 30% verbal cueing needed to decrease the risk of aspiration with puree diet. There was no indication in the record that an assessment had been completed to determine if R89, could be safely fed by a PFA even though they were identified by the ST that they had several occurrences of aspiration pneumonia in the past few months. When interviewed on 2/11/15, at 1:32 p.m. about PFA and resident assessment the registered nurse (RN)-A stated all of the residents who are assisted in the memory care unit were at risk of choking related to their cognitive deficits, "Anybody who needs to be fed is a choking risk." During interview on 2/12/15, at 8:21 a.m. the director of nursing (DON) stated the facility started using PFAs in September 2014. The DON said there was no formal assessments made for R35, R89, R45, R1 and R25 to determine if those residents, who had eating and swallowing difficulties, were eligible to be safely fed by PFAs. The DON said, the nurse assigned to the unit each day "was responsible in making a determination" of who could be assisted by a PFA. When interviewed on 2/12/15, at 3:21 p.m. ST-A stated she had concerns regarding the facilities use of PFA for some time. Some of the PFA had been observed to not understand diet cards, or follow instructions for feeding certain residents.	F 373		

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F 373	Continued From page 43 ST-A added, "I end up giving them a lot of advice." Further, the ST-A stated she had not been consulted in the development of the PFA program used by the facility, "And I would love to be." An undated facility Paid Feeding Assistants policy identified an objective of, "Provide a safe and enjoyable experience for our elders who need assistance with eating their meal." A PFA is identified as, "Anyone who is not licensed personnel who is trained in feeding elders," and, "The resident selection to be fed by a paid feeding assistant will be based on the licensed nurse discretion." Further, the policy identified a procedure of nine steps, including, "Feed elder needing assistance according to the license nurse discretion and under direct supervision of the licensed nurse." The policy lacked any direction to complete an assessment of each resident for safety before being assisted by a PFA.	F 373		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	02/10/2015

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on February 10, 2015. At the time of this survey, Building 01 of Benedictine Living Community Winsted was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	POC ok TB 4-10-15 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4/8/15

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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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 01 of Benedictine Living Community Winsted consists of the original 1960 building. It is two-stories in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type I(332) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a licensed capacity of 65 beds and had a census of 54 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

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	245469	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/10/2015

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K 147	Continued From page 2 This STANDARD is not met as evidenced by: Observations revealed that some electrical installations are not in accordance with NFPA 70 "The National Electrical Code 1999 edition. This deficiency could negatively effect any resident, staff and visitors in this area of the facility. Findings include: On facility tour between the hours of 10:30 am and 1:30PM on 02/10/2015, observations revealed that the 2nd Floor Dining Room had a refrigerator plugged into an electrical power strip. Rooms 219 and 222 also had refrigerators plugged into power strips. The use of a power strip was used in an emergency outlet in room 227 for non-medical equipment and was hanging from the outlet from the wall. This deficient practice was verified by the Environmental Services Director (LZ) and Plant Operations Director (FR)	K 147	All power strips were removed On the same day as the survey 2/10/2015. Inspection of the entire building was done on 2/13/15 by Fran Roufs, Plant operations Manager and Liz Klecker, Director of Environmental Services. Electrician was contacted and he installed additional outlets on 3/4/15 in rooms that were indicated on the survey report. All Emergency outlets were labeled to read "emergency equipment only". The Admission packet includes a reminder to resident/families that power strips/extension cords are not allowed in the building. Monitoring of rooms for power strips/extension cords has been included on the monthly safety rounds inspection forms, which is completed by the Safety Committee Members. The actual completion date and plan of correction was on 3/4/15 by Plant Operations Manager and Director of Environmental Services.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F545 9024

PRINTED: 03/03/2015
FORM APPROVED
OMB NO. 0938-0391

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	245459	A. BUILDING 02 - NEW MAIN ENTRANCE B. WING ______	02/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

(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
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on February 10, 2015. At the time of this survey, Building 02 of Benedictine Living Community Winsted was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. Building 02 of Benedictine Living Community Winsted was constructed in 2011, is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a licensed capacity of 65 beds and had a census of 54 at time of the survey.	K 000	PS 4-10-15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 4/8/15

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.