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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2I21

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00413

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245502**
2.STATE VENDOR OR MEDICAID NO.
(L2) **254740600**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE CARE COMMUNITY**
(L4) **201 9TH STREET WEST**
(L5) **ADA, MN** (L6) **56510**

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) **07/01/2008**

6. DATE OF SURVEY **04/22/2021** (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)
06/30

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

12.Total Facility Beds **49** (L18)
13.Total Certified Beds **49** (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 ___ 6. Scope of Services Limit
___ 3. 24 Hour RN ___ 7. Medical Director
___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size
___ 5. Life Safety Code ___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(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 :
Jennifer Bahr, Unit Supervisor 04/22/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 04/22/2021 (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
11/01/1987
(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

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
04/09/2021 (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 3, 2021

CMS Certification Number (CCN): 245502

Administrator
Benedictine Care Community
201 9th Street West
Ada, MN 56510

Dear Administrator:

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 April 15, 2021 the above facility is certified for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

OrElectronically delivered
May 3, 2021

Administrator
Benedictine Care Community
201 9th Street West
Ada, MN 56510

RE: CCN: 245502
Cycle Start Date: February 19, 2021

Dear Administrator:

On March 9, 2021, we notified you a remedy was imposed. On April 22, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 15, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 23, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 9, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 23, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 15, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 2I21

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00413

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2.STATE VENDOR OR MEDICAID NO.
(L2) **254740600**

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(L3) **BENEDICTINE CARE COMMUNITY**
(L4) **201 9TH STREET WEST**
(L5) **ADA, MN** (L6) **56510**

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) **07/01/2008**

6. DATE OF SURVEY **02/19/2021** (L34)

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0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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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)
06/30

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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
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Amy Charais, FNE - NE II 03/29/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 04/08/2021 (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)

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(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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(L44)
B. Rescind Suspension Date:
(L45)

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01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
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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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
March 9, 2021

Administrator
Benedictine Care Community
201 9th Street West
Ada, MN 56510

RE: CCN: 245502
Cycle Start Date: February 19, 2021

Dear Administrator:

On February 19, 2021, a survey was completed at your facility by the Minnesota Department(s) 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 electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 23, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 23, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 23, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your

obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 23, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Benedictine Care Community will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 23, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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 19, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE CARE COMMUNITY	**201 9TH STREET WEST ADA, MN 56510**

(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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 2/16/21, through 2/19/21, during a recertification survey. The facility was in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 2/16/21, through 2/19/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted during the recertification. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The complaint H5502018C (MN69940 & MN69916) was substantiated at F684. The complaint H5502015C (MN52078) was substantiated; however, no deficiencies were cited due to actions taken by the facility prior to investigation. The following complaint(s) were found unsubstantiated: H5502013C (MN64868). H5502014C (MN48655). H5502016C (MN56234). H5502017C (MN56367). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/16/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE CARE COMMUNITY	**201 9TH STREET WEST ADA, MN 56510**

(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	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		4/15/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE CARE COMMUNITY	**201 9TH STREET WEST ADA, MN 56510**

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F 609	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report allegations of abuse to the State Agency (SA) for 1 of 4 residents (R93) reviewed for abuse. Findings include: R93's quarterly Minimum Data Set (MDS) dated 11/13/20, indicated she had severe cognitive impairment and required extensive assistance for all activities of daily living (ADL)'s. The MDS indicated R93 displayed no behaviors during the assessment period. R93's care plan updated 11/27/20, identified a self care deficit and indicated R93 required assistance from two staff for all ADL's along with use of a left arm sling when out of bed. An untitled facility document dated 8/15/20, written and signed by nursing assistant (NA)-E indicated when checking with R93 on last rounds, R93 stated to NA-E, "don't let [NA-F] take care of me today. The document indicated R93 would not make eye contact with staff when asked "why" she did not want NA-F to take care of her and indicated R93 became teary eyed and stated NA-F was "rough" with her left hand. The issue was reported to the registered nurse (RN) on duty. A facility document Interview with [R93] dated 8/15/20, indicated licensed social worker (LSW)-A interviewed R93 regarding her telling a staff member that NA-F was rough with her. R93 stated when NA-F turned her it hurt her arm and pointed to her shoulder. LSW-A asked if two	F 609	When an allegation of abuse is reported the ED will be notified immediately. ED, DON, or SSD will immediately protect the resident by placing the AP on administrative leave during the investigation. The resident will be interviewed as well as the other residents in a expanded risk group. The resident will be assessed for injury and receive medical attention as indicated. The report will be made immediately to the state agency and the investigation will be completed and submitted within 5 days. Care plan will be updated as appropriate. AP and other staff will be interviewed as part of the investigation. Corrective action and training will be completed as appropriate. R93 Care plan was updated: PROBLEM: I don't like to be rushed and may perceive this as being rough. APPROACH: Please have patience when caring for me. Go slowly and explain the process. Allow me to control and help as much as I am able. Facility will assure compliance by auditing. On 03/15/2021 and 03/16/2021 a sample of 10 residents were interviewed regarding the care they receive from staff ad if they have had care concerns of staff being rough or speaking rudely to them. Those interviews were reviewed by the DON and administrator. Plan is to interview 10 residents a week for 2 weeks then 5 residents for 2 weeks then 5 residents per month. Interviews will be reviewed by DON, LSW and Administrator	

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F 609	Continued From page 3 people were providing care and R93 stated they usually did. R93 requested a different caregiver but indicated she did not feel NA-F was hurting her on purpose. R93 agreed to having NA-F take care of her if NA-F was educated to "go slower." A facility document Interview with NA-F dated 8/15/20, indicated LSW-A discussed with NA-F the concern that she had been rough with R93 and hurt her arm when moving her around. LSW-A asked if R93 had ever complained of pain and NA-F stated yes and that she felt bad and tried not to hurt R93. NA-F stated R93 was very protective of her arm. A staff interview dated 8/19/20, four days after the report, indicated NA-H asked if she had observed anyone hurting R93. NA-H stated "no" but stated R93 had asked to not have NA-F as a caregiver one day, and said "I believe it was Saturday." The staff interview form indicated "please complete and place in [LSW-A] box as soon as possible. A staff interview dated 8/27/20, twelve days after the report, indicated a NA-G stated she had not observed anyone being rough with R93 but stated R93 often talked about a staff member who was rough with her. The staff member further stated R93 talked about NA-F and that R93 would like NA-F to be more gentle and had requested NA-F not wash her up in the morning. The staff interview form indicated "please complete and place in [LSW-A] box as soon as possible. During interview on 2/18/21, at 3:15 p.m., LSW-A stated the allegation of rough treatment had not been reported to the SA. LSW-A stated she did an internal investigation and determined it was not reportable.	F 609	for reportability. This audit will be reported to Quality Council quarterly. All staff will receive re-education on the abuse prevention policy and reporting requirements on 03/18/2021. All audits to continue per QUAPI	

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F 609	Continued From page 4 On 2/19/21, at 8:14 a.m. LSW-A stated she did some further checking into the incident and stated the incident occurred on a Saturday and she went to the facility to talk to R93. LSW-A stated R93 told her "yep, she [NA-F] treats me rough. LSW-A stated R93 said it was more that NA-F moved too fast. LSW-A stated she had already decided it was not abuse and the rest of the staff interviews were "more of a fact check." A facility policy Abuse Prevention Plan dated 2017, indicated all allegations of abuse would be investigated by the director of social services, director of nursing or their designees. Staff were to notify the building charge immediately of any reports of possible abuse, neglect, misappropriation..... The charge would immediately notify the administrator or designee. The policy directed staff to report allegations of abuse immediately upon receiving a report of possible abuse.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 610		4/15/21

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F 610	Continued From page 5 designated representative and to other officials in accordance with State law, including to the State Survey 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 thoroughly investigate allegations of verbal abuse by staff for 1 of 4 residents (R44) reviewed for abuse. Findings include: R44's quarterly Minimum Data Set (MDS) dated 8/13/20, identified R44 had moderate cognitive impairment and was independent with bed mobility, transfers and toileting. The MDS indicated R44 was frequently incontinent of bladder and did not display rejection of care behaviors. R44's care plan dated 8/26/20, identified a self care deficit related to toileting, dressing and bed mobility and directed staff to assist with toileting every three to four hours and at 2:00 a.m. and 5:00 a.m. to help prevent skin breakdown and respect dignity. A report to the state agency (SA) dated 9/3/20, indicated on 9/1/20, nursing assistant (NA)- A reported to licensed social worker (LSW)-A she heard R44 tell another un-named staff member that during the night shift a few days prior, NA-A had called R44 a "dirty b****." NA-A denied calling R44 the name. The report indicated a full investigation was to be completed. An Investigation Report Summary submitted to	F 610	When an allegation of abuse is reported the ED will be notified immediately. ED, DON, SSD will immediately protect the resident by placing the AP on administrative leave during the investigation. The resident will be interviewed as well as other residents in a expanded risk group. The resident will be assessed for injury and receive medical attention as indicated. The report will be made immediately to the state agency and the investigation will be completed and submitted within 5 days. Care plan will be updated appropriate. AP and other staff will be interviewed as part of the investigation. Corrective action and training will be completed as appropriate. R44 resident is no longer in the facility. On 03/15/2021 and 03/16/2021 a sample of 10 residents were interviewed regarding the care they receive from staff and if they had a care concern of staff being rough or speaking rudely to them. Those interviews were reviewed by DON and Administrator. All staff will receive re-education on the abuse prevention policy and reporting requirements on 03/18/2021. Facility will assure compliance by auditing OHFC investigations for complete	

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F 610	Continued From page 6 the SA dated 9/11/20, indicated R44 reported the incident happened on Sunday night and NA-A reported the incident occurred early Tuesday morning. NA-A reported she woke R44 at 2:00 a.m. per her care plan and noted R44's bed smelled like urine and she asked R44 to go to the bathroom so she could change the bedding. R44 refused and was asked again at 5:30 a.m. and refused again. At 6:00 R44 went to the bathroom and NA-A thanked her. NA-A denied calling R44 a "dirty b****." The summary indicated R44 had a pattern of attention seeking behavior, example: stating she had a bladder infection when no infection present. The investigation report indicated an un-named licensed practical nurse (LPN) on the shift reported NA-A had been trying to get R44 up but denied hearing her call R44 the name. The investigation lacked evidence other staff or residents were interviewed, including the unnamed NA whom NA-A heard R44 talking to. During interview on 2/18/21, at 3:15 p.m. LSW-A stated following the report to the SA she had spoken to R44 and spoken to NA-A. LSW-A spoke to other staff who may have heard something and then went back and talked to R44. R44 had talked to other staff so she went back to R44 to get other clarification. LSW-A had not asked any other residents if they had concerns about NA-A as a caregiver and stated "in general, if I had concerns I would probably go around and ask." Further, LSW-A stated NA-A reported overhearing R44 tell another staff member about the incident but LSW-A did not know who the other staff was and had not asked. The internal facility investigation identified the following interviews:	F 610	investigation including members of the expanded risk group of other residents and staff that worked with the AP at Quality Council monthly. All audits to continue per QUAPI	

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F 610	Continued From page 7 - An untitled facility document dated 9/3/20, signed by NA-A indicated on Tuesday August 1st, NA-A entered R44's room and asked R44 to please go to the bathroom and R44 refused. NA-A returned later and asked R44 again to go and told R44 "please go to the bathroom, your bed smells like urine and I would like to clean it." R44 again refused toileting. Closer to 6:00 a.m. R44 stated she had gone to the bathroom and NA-A reported telling R44, "Awesome, thank you." NA-A denied calling R44 a "dirty b****." - A facility document Interview With [R44] by LSW dated 9/3/20, indicated R44 reported on Sunday night NA-A called her a "dirty b****." When asked what led up to the comment R44 stated nothing. R44 reported NA-A asked her to get up and go to the bathroom and she did. That was when NA-A called her the name. R44 stated no one else was present at the time and R44 had not mentioned it to anyone. On 2/19/21, at 8:18 a.m. LSW-A stated she had done some checking into the incident involving R44 and stated there were a lot of interviews missing. LSW-A stated she had interviewed other staff and had interviewed R44 two or three times but was unable to find the interviews. The facility policy Abuse Prevention Plan dated 2017, indicated following a report to the SA, the director of social services, director of nursing or designee will submit the facility's investigative report to the SA. The policy did not identify components of a thorough investigation, nor what information would be retained as part of the investigation.	F 610		
F 661 SS=D	Discharge Summary	F 661		4/15/21

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F 661	Continued From page 8 CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive discharge summary including a recapitulation of stay was completed and provided at the time of transfer, to ensure continuity of care, for 2 of 2 residents (R91, R41) who were reviewed for discharge practices.	F 661	Plan of care completed at time of discharge and sent. RN's have been educated on items needed in a discharge summary and POC on 03/16/2021. DON will audit documentation weekly and until there is a resolution on discharged	

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F 661	Continued From page 9 Findings include: R1's annual Minimum Data Set (MDS) dated 1/25/21, identified R91 had mild cognitive impairment and required extensive assistance with most of his activities of daily living (ADLs). Further, the MDS outlined R91 had several medical diagnoses including flaccid hemiplegia affecting left side (severe or complete loss of motor function on one side of the body), cellulitis of the left lower limb, chronic obstructive pulmonary disease, muscle weakness, generalized edema, a history of venous thrombosis (the formation of a blood clot inside a blood vessel, obstructing the flow of blood through the circulatory system) and generalized anxiety disorder. R91's progress note(s) identified the following: - On 2/3/21, a discharge conference was held with a plan to discharge to an assisted living on 2/9/21. - On 2/9/21, indicated R91 was discharged from the facility and RN-B had called the assisted living and completed a nurse to nurse report. The progress note did not identify what was discussed. R91's discharge summary dated 2/9/21, identified R91 discharged to a local assisted living. The discharge summary lacked a recapitulation of stay identifying the following: customary routine, cognitive patterns, communication, vision, mood and behavior patterns, psychosocial well-being, physical functioning and structural problems, continence, disease diagnoses and health	F 661	residents to ensure it includes that sections are complete and will report on it at Quality Council on 04/15/2021. All residents discharged since 2/19 will be audited to ensure that discharge summary and plan of care are complete. Audit to continue per QUAPI	

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F 661	Continued From page 10 conditions, dental and nutritional status, skin condition, activity pursuit, special treatments and reconciliation of all pre-discharge medications with the resident's post-discharge medications. R41's care plan dated 1/22/20, identified a diagnosis of cognitive loss but indicated he was alert and oriented. The care plan identified a self care deficit with activities of daily living, need for range of motion services related to pain, urinary incontinence and indicated he used a walker and a wheel chair. The care plan further identified behaviors that included refusing assistance with toileting and locking himself in the bathroom. R41's progress note dated 1/14/21, indicated a face to face discharge exam was completed due to planned discharge to assisted living facility (ALF). ALF assessed R41 and felt he was appropriate for discharge to their facility. R41 expressed concern with frequent voiding and being up every 1-2 hours during the night to urinate. The note indicated R41 was unable to use his walker until fractured wrist was healed. R41's Discharge Summary dated 1/27/20, indicated R41 admitted to the facility on 12/2/19, and required extensive assistance from one to two staff upon admission. The summary indicated R41 discharged from the facility on 1/27/20, and indicated he received physical therapy,	F 661		

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F 661	Continued From page 11	F 661		

occupation therapy and speech language services while at the facility and fractured his wrist on 12/27/20. The Discharge Summary further indicated R41 was unable to walk due to non-weight bearing status of wrist.

The discharge summary lacked a recapitulation of stay identifying the following: customary routine, cognitive patterns, communication, vision, mood and behavior patterns, psychosocial well-being, physical functioning and structural problems, continence, disease diagnoses and health conditions, dental and nutritional status, skin condition, activity pursuit, special treatments and reconciliation of all pre-discharge medications with the resident's post-discharge medications.

During interview on 2/19/21, at 10:35 a.m. the director of nursing (DON) stated she did not know if the discharge summary went with the resident when they transfer. The DON indicated a lot of information related to the resident care needs, behaviors and changes were communicated through nurse to nurse report. The discharge summary did not get sent with the resident when they transferred to another level of care, as it was done after the resident had discharged. The progress notes and care plan were sent with the resident. The DON had been told the facility had some time to complete the discharge summary, so the summary was not sent with residents on transfers.

The facility's undated Discharge Planning policy identified transfer or discharge must be documented and include history of present illness, reason for transfer, past medical/surgical history, exchange with receiving provider or

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F 661	Continued From page 12 facility. Information provided to the receiving provider must include the following: contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, advance directive on file, all special instructions or precautions for on-going care if appropriate, comprehensive care plan goals and all other necessary information, including a copy of the discharge summary.	F 661		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure weights and edema were assessed, monitored and interventions implemented for 1 of 1 resident (R91) reviewed for weight gain with edema. Findings include: R91's annual Minimum Data Set (MDS) dated 1/25/21, identified R91 had mild cognitive impairment and required extensive assistance with most of his activities of daily living (ADLs). Further, the MDS outlined R91 had several medical diagnoses including flaccid hemiplegia	F 684	R91 was discharged from facility on 2/9/21. All residents that trigger for > or < 5lb weight gain will be reweighed. Assessments of weight gain should include assessment for edema. DON and dietician will audit weights weekly and ensure proper documentation and assessment completed. DON will educate RN's on assessment and documentation needed with weight gain and weight loss on 03/16/21. All audits will be reviewed at Quality Council on 4/15/21. Audits to continue per	4/15/21

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F 684	Continued From page 13 affecting left side (severe or complete loss of motor function on one side of the body), cellulitis of the left lower limb, chronic obstructive pulmonary disease, muscle weakness, generalized edema, a history of venous thrombosis (the formation of a blood clot inside a blood vessel, obstructing the flow of blood through the circulatory system) and generalized anxiety disorder. R91's physician office visit, dated 1/21/21, indicated skin was warm and dry with no rashes and no ankle edema was noted. R91's physician order dated 1/29/21, indicated R91 received furosemide (a medication to reduce fluid retention) 40 milligrams (mg) daily. The order lacked direction or parameters of when to notify the physician of weight gain. R91's care plan dated 1/19/21, indicated R91 was at risk for weight loss due to his poor to fair intake and history of eating poorly. The care plan also indicated R91 required assistance with dressing, toileting and grooming and had a potential for skin breakdown. R91 wore a white boot when in bed and a brace when he had a shoe on. The care plan directed staff to assist R91 with cares daily and to lotion and inspect his skin daily with cares and bath. R91's weights and vitals summary indicated the following weights were obtained: -On 1/23/21, R1's admission weight was recorded as 199 pounds (lbs). -On 1/27/21, R1's weight was recorded as 213 lbs. -On 2/4/21, R1's weight was recorded as 219 lbs.	F 684	QUAPI. All residents with weight gain or loss in previous one month were audited for appropriate intervention. If weight change >5% increase in 30 days RN or Dietician will assess and document findings. All residents will be audited from 2/19 to ensure weight changes have been documented and assessed. All audits to continue per QUAPI.	

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R91's progress note(s) identified the following:
-1/21/21, at 1:16 p.m. Independent with eating. Today he has refused all meals, just requesting orange juice and crackers.
-1/22/21, at 17:15 p.m. Appetite was poor, requesting graham crackers and orange juice for supper.
-1/23/21, at 11:14 a.m. Admission nutritional assessment completed. Resident was at moderate nutritional risk due to poor po (by mouth) intakes at meals. He was choosing to eat graham crackers and orange juice at meals and snacks at this time. His current wt is 199.5 lbs.
-1/28/21, at 11:11 a.m. Discussed at interdisciplinary team meeting (IDT): weight 213 lbs. up from 199.4 lbs on 1/23/21. Weight gain was related to better intake and nutrition.
-2/1/21, at 2:50 p.m. Resident was independent with eating after set up. Minimal appetite. Took supplement drinks.
-2/3/21, at 12:02 p.m. Resident was independent with eating after set up. Minimal appetite. Took supplement drinks.

R91's skin assessment dated 1/19/21, identified R91's right lower leg had a dusky discoloration to the area. There was a scabbed area on the left shin and on top of the left foot.

R91's medical record lacked documentation related to his continued weight gain on 2/4/21, as well further skin assessments or monitoring for edema.

During an internal investigation into R91's care, the facility's licensed social worker (LSW) conducted interviews with the nursing staff assisting R91 with daily cares. Of the twenty-one staff interviewed, three nursing assistants were

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able to identify they had visualized R91's feet during cares, they had provided on three separate occasions. The nursing assistants all reported although edema was noted, the skin was dry and intact. All other staff stated R91 always had his socks on and they had not seen his feet.

R91's medical record indicated he was discharged to an assisted living (AL) on 2/9/21. A telephone nurse report was given to the nurse at the AL, however, the record lacked documentation of what was reported.

During a telephone interview with AL regiseted nurse (RN)-C on 2/18/19, at 10:03 a.m. RN-C indicated R91 arrived on 2/9/21, however, due to findings during his admission assessment, R91 was transferred to the hospital for evaluation. RN-C identified R91's skin on his lower left extremity was red, swollen and an open draining area was noted on top of his left foot. RN-C contacted the LSW of the discharging facility and was told the condition of R91's left lower extremity must have developed in the last five days of his stay at the facility, as no problems were noted on his last bath day on 2/4/21, and there were no orders for wound care.

During telephone interview on 2/18/21, at 10:35 a.m. R91 stated the swelling in his leg had been going on for awhile. R91 indicated the nursing staff at the nursing home had looked at his leg but they did not do anything for it.

On 2/18/21, at 12:40 p.m. nursing assistant (NA)-B stated she had given R91 a bath on 2/4/21, and had noted the skin on his lower extremities was dry and intact. NA-B indicated he had some edema but it was not excessive,

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therefore it was not reported to the nurse.

On 2/18/21, at 1:19 p.m. NA-D stated she recorded resident weights on a chart when she completed the baths. If a resident had a weight gain or loss of 3 pounds or more, she notified the nurse.

During interview on 2/18/21, at 2:47 p.m. with registered nurses (RN)-A and RN-B, RN-B stated residents were weighed weekly and they would only weigh a resident more often if the physician ordered it or if the dietician felt it was needed. If a resident had edema, the staff would assess it as needed. RN-A indicated she read the residents progress notes, events and vital signs out of range each day when she started her shift. R91's weight gain was discussed at IDT on 1/28/21, however the facility did not notify the physician of R91's weight increase. R91 had an internal medicine appointment on 1/28/21, he did not have respiratory distress and the thought was the weight increase was related to improved nutrition, so they did not feel physician notification was needed.

On 2/19/21, at 10:13 a.m. registered dietician (RD) stated she had noted R91's 14 lb. weight gain but had just assumed the weight was inaccurate. The RD indicated she had not requested a re-weigh or documented the weight increase in the medical record and the weight discrepancy should have been documented and communicated to nursing staff. The RD stated she had not noticed the subsequent 6 lb. weight gain the following week and she should have addressed it. Typically she would have notified nursing staff and request an assessment. The RD stated the second weight increase must have

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F 684	Continued From page 17 gotten missed. On 2/19/21, at 11:40 a.m. the director of nursing (DON) indicated R91's first weight was probably inaccurate as he was resistive to being weighed that day, however a re-weigh was not done. After performing a quick review in R91's electronic hospital record the DON stated the record showed R91's hospital weight on the day of his discharge was 213 pounds. A weight gain of 14 pounds in one week from improved nutrition would be unusual and should be investigated. The DON indicated R91 wore an ankle-foot orthoses (AFO) brace that had a potential risk for skin breakdown and changing R91's socks and inspecting his skin would be an expectation when assisting R91 with his daily care. The facility's undated policy Prevention and Treatment of Skin Breakdown, indicated maintaining intact skin is integral to resident health and wellness. Skin was observed daily with cares. Weekly skin audits were performed by a licensed nurse. A policy for monitoring weights for residents was requested, however, none was provided.	F 684		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758		4/15/21

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F 758	Continued From page 18 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758		

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F 758	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a gradual dose reduction and/or evidence a justification of continued use was obtained for psychotropic (mood altering) medications was for 1 of 3 residents (R13) reviewed who received psychotropic medications. Findings include: R13's annual Minimum Data Set (MDS) dated 2/11/20, indicated R13 had severe cognitive impairment with diagnosie of dementia, and mood disorder. The MDS further indicated R13 had no mood symptoms, psychosis, behavioral symptoms, rejection of care or wandering. The MDS indicated R13 received antipsychotic and antidepressant medications daily and no gradual dose reduction had been attempted. R13's Physician Order Report dated 1/19/21 - 2/19/21, included a physician order for olanzapine (an antipsychotic) 15 milligrams (mg) by mouth one time a day related to an unspecified mood disorder. The order start date was identified as 1/4/19. A physician order for sertraline (antidepressant) 150 mg one time a day related to depression was also listed. The order start date was identified as 1/5/19. R13's care plan dated 12/21/20, indicated R13 was at risk for complication related to olanzapine and sertraline and and intervention included the medical doctor and pharmacy would review per guidelines for gradual dose reductions (GDR). On 2/18/21, at 9:09 a.m. R13 was seated in her	F 758	R13 will have psychotropic review by her psychologist on 03/31/21 for GDR recommendation. All residents will have GDR's to ensure clinical rationale is checked by 04/13/2021. Facility GDR form will be adapted so providers can check the rationale box to agree with the RN assessment. RN's and providers will be educated by 3/19/21 on the new form. DON will audit GDR forms for compliance for checking appropriate rationale weekly and report to Quality Council on 04/15/21. Audits to continue per QUAPI	

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wheelchair near the nurses station. R13 was fully dressed and groomed, wearing a surgical face mask and her chin was resting on her chest with her eyes closed.

-At 12:21 p.m. R13 was seated in her wheelchair in the dining room, quietly watching people as they passed by.

-At 1:47 p.m. R13 was quietly wheeling her wheelchair about the hall of her wing. An unidentified staff member pushed R13's wheelchair to a nearby table to offer her a snack.

On 2/19/21, at 7:57 a.m. R13 was observed sitting in her wheelchair near the nurses station. R13 was fully dressed and groomed, and was sleeping quietly in her chair. No behaviors were noted.

During interview on 2/18/21, at 7:59 a.m. trained medication aide (TMA)-A stated R13's behaviors were pretty good as she rarely gots mad toward staff and never hit out. TMA-A indicated R13 enjoyed reading and did not bother other residents. R13 did respond well to verbal redirection and giving her a baby doll to hold was another effective intervention.

-At 8:01 a.m. TMA-B stated R13 would get a little aggressive when assisted with personal cares but responded really well to redirection or to leave her for a few minutes and then re-approach. TMA-B stated R13 never bothered other residents and holding a baby doll or her animated plush cat was an effective intervention when she was anxious.

R13's consultant pharmacist's monthly medication reviews identified the following:

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- On 10/29/20, please prompt a GDR evaluation on olanzapine and sertraline.

- On 11/25/20, waiting response to 10/20, recommendation to prompt a GDR on both olanzapine and sertraline.

- On 12/29/20, have provider document clinical rationale on 8/20, GDR forms for both olanzapine and sertraline. The clinical rationale was not documented.

- On 1/25/21, med review complete. GDR forms for both olanzapine and sertraline to be addressed with psychiatric provider at next visit.

R13's medical record identified the following regarding R13's psycotropic medications:

- On 9/18/19, R13 was seen at neuroscience clinic. The nurse practioner (NP) documented to continue olanzapine as R13 was not a candidate for GDR given history and breakthrough symptoms. However, sertraline was documented to continue med with no GDR evaluation.

- On 12/17/19, A Psychopharmacological Medications Tapering Attempt (MTA) form for olanzapine was signed by R13's primary medical doctor (MD). The MD checked no change to current dose with following rationale: needed to maintain residents function and GDR would likely cause resident distress. Decrease or change is likely more harmful to resident than maintaing current dose. However, a sertraline GDR was not addressed.

On 11/18/20, The MTA form for olanzapine was

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signed by R13's primary MD, however, the question is a tapering attempt possible, was not addressed and the clinical rationale lacked any documentation.

On 11/18/20, The MTA form for sertraline was signed by R13's primary MD, however, the question is a tapering attempt possible, was not addressed and the clinical rationale lacked any documentation.

On 12/8/20, A separate MTA form was filled out by nursing for both sertraline and olanzapine, however, the forms did not indicate if a tapering attempt was possible, clinical rationale or physician signature.

R13's medical record lacked any documentation of a GDR attempt or clinical rationale of why an attempt could not be made for the year 2020.

On 2/19/21, at 8:49 a.m. RN-D stated the nurses had a flow sheet they uses to track when a psychotropic medication was started, when it is up for review and if there was a doctor note completed. The nurses filled out a quarterly evaluation form on psychotropic medications and gave them to the doctor. The doctor scans them back to the facility and they are reviewed by the case manager. If it is not filled out adequately, it is resent to the doctor to complete. R13's psychotropic medications were done by her psychiatric doctor. She was due to be seen in January.

During interview on 2/19/21, at 11:29 a.m. the DON stated R13's last psychiatrist visit in September 2019, indicated R13 was not a candidate for reduction. Her primary doctor will

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F 758	Continued From page 23 not change any psych medications because she was being seen by psychiatry. R13 was unable to be seen by psychiatry due to the covid pandemic. The DON indicated R13's family wanted R13's psychotropic medications continued and there was a discussion regarding a psychiatric appointment. The facility was in the process of getting something scheduled. The facility's undated Psychotropic Medication Use policy indicated psychotropic medications were given upon a medical provider order. The nursing associates collaborate with the medical provider to ensure the lowest possible dosage is given for the shortest period of time and are subject to gradual dose reductions and re-review. GDR begins within the first year in which a resident is admitted or newly prescribed a scheduled psychotropic medication. GDR was attempted in two separate quarters, unless clinically contraindicated and documented by the medical provider. The continued use is in accordance with relevant current standards of practice and the medical provider has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder.	F 758		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		4/15/21

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F 880	Continued From page 24 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880		

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F 880	Continued From page 25 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly quarantine new admissions from other residents, as directed by the Centers for Disease Control (CDC) in order to minimize or prevent the potential spread of COVID-19 for 2 of 2 residents (R18, R191) who admitted/re-admitted to the facility from an acute care setting and were placed with non COVID positive residents who resided in the facility and did not require quarantine. This practice had the potential to affect all 40 residents who resided in the facility. Findings include: The CDC guidelines for cohorting of residents dated 4/30/20, indicated the facility should create a plan for managing new admissions and	F 880	R191 has discharged from facility. R18 has been taken off quarantine precautions at this time. LSW, DON and Administrator will decide room placement for all admissions and re admissions and follow CMS guidance. All staff will be educated on 03/18/21 on current CMS guidance on co-horting residents. DON/designee will audit daily that all admissions/re-admissions are appropriatley placed based on CMS guidance. Audits will be brought to Quality Council on 04/15/21. Audits to continue through QUAPI. New admissions and re-admissions will have designated area to quarantine if not 2 weeks post vaccinated or exposed.	

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F 880	Continued From page 26 readmissions whose COVID-19 status was unknown. Options included placement in a single room or in a separate observation area so the resident could be monitored for evidence of COVID-19. R18's quarterly MDS dated 12/25/20, indicated she had moderate cognitive impairment and required extensive assistance for bed mobility, transfers and toileting. The MDS indicated R18 received oxygen therapy during the assessment period. R18's care plan dated 11/27/20, identified a risk for infection related to COVID-19 pandemic. R18's care plan further identified a diagnosis of respiratory disease, asthma, and indicated the use of oxygen. The care plan indicated R18 did not wear a mask in her room due to a history of shortness of breath. R23's quarterly MDS dated 12/30/20, indicated she had severe cognitive impairment and required extensive assistance for bed mobility, transfers and toileting. The MDS indicated R23 received oxygen therapy during the assessment period. R23's care plan dated 2/10/21, identified a risk for infection due to COVID-19 pandemic with confirmed cases reported in the county. The care plan further identified an alteration in respiratory status and use of oxygen and indicated she did not wear a mask in her room due to a history of shortness of breath. R23's Resident Census printed 2/19/21, indicated she discharged to the hospital on 2/5/21, and returned to the facility on 2/8/21, to	F 880	*added attachments for the DPOC 03/19/21 5:30pm	

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(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 880	Continued From page 27 her previous room which she shared with R18. R191's annual Minimal Data Set (MDS) dated 2/11/21, indicated R191 was cognitively intact and required limited assist to dress and groom and extensive assist with transfers and toileting. R191's diagnoses included weakness, heart disease and chronic obstructive pulmonary disease. R191's care plan dated 2/16/21, identified a risk for infection due to COVID-19 pandemic with confirmed cases reported in the county. The care plan further identified R191 was new to the facility after being in the hospital for a couple of nights. R36's quarterly MDS dated 1/29/21, indicated R36 had no cognitive impairment. R36 required limited assist with transfers and ambulation and extensive assistance with dressing, grooming and toileting. R36's diagnoses included diabetes, chronic kidney disease, and hypertension. R36's care plan, last revised 2/8/21, identified a risk for infection due to COVID-19 pandemic with confirmed cases reported in the county. The care plan further identified R36 was at risk for complications related to a diagnosis of diabetes. The Resident Bed List Report dated 2/16/21, indicated R36 and R191 shared a room. On 2/16/21, at 3:24 p.m. R191 stated she was unable to walk in the halls or attend activities as she was confined to her room for 14 days. R191	F 880		

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	245502	A. BUILDING _____ B. WING _____	C 02/19/2021

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F 880	Continued From page 28	F 880		

indicated she was quarantined as she was a new admission from the hospital.

On 2/18/21, at 7:49 a.m. nursing assistant (NA)-B was observed to enter R36's double occupancy room and assist R36 to a bathroom shared with her roommate, R191. R36 was not wearing a surgical mask. NA-B assisted R36 to undress and sit on the toilet. NA-B assisted R36 to brush her teeth, dress and groom, while seated on the toilet in the shared bathroom. NA-B was wearing a surgical face mask, gloves and goggles, however, was not wearing an isolation gown.

NA-B stated transmission based precautions were not required when caring for R36 as it was the roommate who was under quarantine and not R36. Transmission based precautions were required to care for R191, who shared the room and bathroom, as she was a recent admission from the hospital. Both residents did use the common shared bathroom.

On 2/18/21 at 12:05 p.m. NA-B was observed to assist R36 to ambulate from her room to the dining room with gait belt and walker. R36 was wearing a cloth face mask. NA-B was wearing goggles and face mask. R36 was assisted to sit in the dining room and served her lunch, where other residents were present.

During interview on 2/18/21, at 9:18 a.m. the director of nursing (DON) stated there was an infection preventionist (IP) for the facility, registered nurse (RN)-D, who works on site at least one day weekly and her weekend rotation. The facility allotted five hours per week for the infection control program. The DON telephoned RN-D, who joined the interview. RN-D stated

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F 880	Continued From page 29	F 880		

new admissions came to the facility with a current negative covid test and were quarantined for the first fourteen days of their stay.

The DON explained the facility was at a disadvantage with only having a few private rooms and so they had to consider whether it was a male or female admission. The facility tried to place new admissions into private rooms but it was rarely possible. This was why the facility required a recent negative covid-19 test prior to admission. Staff were required to wear gowns, goggles, masks and gloves when caring for quarantined residents, otherwise surgical masks, goggles and gloves when indicated was required to care for all other residents. Placement of new admissions depended on what rooms were open.

The DON stated she and the IP nurse considered many factors when placing a new admission, such as resident personalities, the track for the lift, and bathrooms. The DON acknowledged the facility did have four beds in their covid-19 unit, each room housed one male resident. One had been released from quarantine restrictions over a month ago and the other yesterday. The facility had decided they were unable to move the men off the COVID-19 unit due to difficulty placing them with other male residents. The DON indicated although the current census was 40 and the facility's capacity was for 49 residents, they were unable to juggle residents and rooms to obtain a private room for the new admission R191.

They were unable to place R191 in one of the four covid beds because a male resident was residing in each of the two double occupancy rooms. The DON stated the male residents had

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F 880	Continued From page 30 completed their 14 day quarantine period and no longer required the COVID-19 unit beds. The DON explained R36 was not under quarantine, however, did share a room with the quarantined new admission R191. The two residents did share a common bathroom and neither residents wore personal protective equipment (PPE) in their rooms or bathroom. The DON indicated R191 had a negative Covid-19 test just prior to admission and had received her first dose of the Covid-19 vaccine shortly after her admission to the facility. The DON indicated all the residents residing in the facility had received at least one dose of the Covid-19 vaccine and most had completed both the doses of the vaccine. On 2/18/21, The facility's current resident roster indicated three male residents resided alone in double occupancy rooms and three female residents resided alone in double occupancy rooms. The facility's undated policy, Management of Admissions and Readmissions indicated if a resident is not known or suspected to be infected with COVID-19 the facility would place the resident in transmission-based precautions in a separate observation area or ideally, in a single-person room for 14 days after admission. If unable to have resident in a private room, ensure that new admission has a negative covid test and put them under transmission based precautions in a semiprivate room with a non Immunocompromised resident.	F 880		
F 921 SS=C	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions	F 921		4/15/21

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F 921	Continued From page 31 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to regularly clean a refrigerated cart which stored food for resident consumption. This had the potential to affect all 40 residents who received meals from the kitchen. Findings include: During observation on 2/19/21, at 9:30 a.m. during follow up kitchen, a Chef Base two drawer refrigerated cart was in use next to the flat top grilling station. Upon opening the top drawer, there were several containers of food (onions, pickles, tomatoes, cheese, and bacon suspended from drawer separators and the bottom of the drawer was open to the rest of the Chef Base refrigerator and food could fall through the drawer. There was old food debris on the drawer separators and on the rail between the two drawers. The bottom drawer had two empty hanging containers in them, and the bottom rail had small pieces of food setting on them. The bottom of the cart and had liquid all over the bottom about 3/8 of an inch deep with what looked like a brown paper towel used to dry your hands in the liquid. The facility's Weekly Cleaning Schedule dated 1/26/21-2/1/21, identified a cleaning schedule for refrigerators and other equipment in the kitchen; however, did not identify the Chef Base refrigerator.	F 921	The Chef Base refrigerator will be added to the weekly and daily cleaning list. Specifically requiring the unit drawers to be wiped down daily and the drip tray observed weekly and attended to/drained as needed. Prep cooks and Cooks will have one on one training showing them how to clean the chef base refrigerator as indicated in the equipment manual. This will be completed by 03/22/21. Prep Cooks and Cooks will be responsible for signing off that the task has been completed. Culinary Manager will audit the cleaning schedules weekly to ensure Prep cooks and cooks are cleaning and understanding the process. This will be reviewed at Quality Council quarterly. Audits to continue per QUAPI.	

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F 921	Continued From page 32 During interview on 2/19/21, at 9:30 a.m. with the supportive services director (SSD-A), who was in charge of the kitchen, stated they do not know if Chef Base refrigerator had ever been deep cleaned and identified it needed to be. The SSD-A stated the Chef Base refrigerator was not on the regular cleaning schedule. A request was made for cleaning procedures related to the Chef Base refrigerator, but none was received. The facility's undated Equipment Operations and Cleaning Procedures indicated the Culinary Services Director was responsible for developing clean procedures for all equipment. Cleaning procedures should be available for each piece of equipment. The Culinary Services Director would instruct employees on cleaning of equipment. The undated, manufacturer's instructions for the Chef Base refrigerator identified how to conduct regular cleanings. Instruction were included on how to remove components of the drawers for cleaning and instructions on cleaning the inside of the Chef Base refrigerator and ensuring drain is not clogged.	F 921		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 9, 2021

Administrator
Benedictine Care Community
201 9th Street West
Ada, MN 56510

Re: State Nursing Home Licensing Orders
Event ID: 2I2111

Dear Administrator:

The above facility was surveyed on February 16, 2021 through February 19, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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

Please 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.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/16/21, through 2/19/21, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID	

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2 000	Continued From page 1 The complaint H5502018C (MN69940 & MN69916) at MN Rule 4658.0520 Subp. 1 0830 The complaint H5502015C (MN52078) was substantiated; however, no deficiencies were cited due to actions taken by the facility prior to investigation. The following complaint(s) were found unsubstantiated: H5502013C (MN64868). H5502014C (MN48655). H5502016C (MN56234). H5502017C (MN56367). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction	2 000	Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR	

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2 000	Continued From page 2 is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000	VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure weights and edema were	2 830	Corrected	4/15/21

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2 830	Continued From page 3 assessed, monitored and interventions implemented for 1 of 1 resident (R1) reviewed for weight gain with edema. Findings include: R1's annual Minimum Data Set (MDS) dated 1/25/21, identified R91 had mild cognitive impairment and required extensive assistance with most of his activities of daily living (ADLs). Further, the MDS outlined R91 had several medical diagnoses including flaccid hemiplegia affecting left side (severe or complete loss of motor function on one side of the body), cellulitis of the left lower limb, chronic obstructive pulmonary disease, muscle weakness, generalized edema, a history of venous thrombosis (the formation of a blood clot inside a blood vessel, obstructing the flow of blood through the circulatory system) and generalized anxiety disorder. R91's physician office visit, dated 1/21/21, indicated skin was warm and dry with no rashes and no ankle edema was noted. R91's physician order dated 1/29/21, indicated R91 received furosemide (a medication to reduce fluid retention) 40 milligrams (mg) daily. The order lacked direction or parameters of when to notify the physician of weight gain. R91's care plan dated 1/19/21, indicated R91 was at risk for weight loss due to his poor to fair intake and history of eating poorly. The care plan also indicated R91 required assistance with dressing, toileting and grooming and had a potential for skin breakdown. R91 wore a white boot when in bed and a brace when he had a shoe on. The care plan directed staff to assist R91 with cares	2 830		

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2 830	Continued From page 4 daily and to lotion and inspect his skin daily with cares and bath. R91's weights and vitals summary indicated the following weights were obtained: -On 1/23/21, R1's admission weight was recorded as 199 pounds (lbs). -On 1/27/21, R1's weight was recorded as 213 lbs. -On 2/4/21, R1's weight was recorded as 219 lbs. R91's progress note(s) identified the following: -1/21/21, at 1:16 p.m. Independent with eating. Today he has refused all meals, just requesting orange juice and crackers. -1/22/21, at 17:15 p.m. Appetite was poor, requesting graham crackers and orange juice for supper. -1/23/21, at 11:14 a.m. Admission nutritional assessment completed. Resident was at moderate nutritional risk due to poor po (by mouth) intakes at meals. He was choosing to eat graham crackers and orange juice at meals and snacks at this time. His current wt is 199.5 lbs. -1/28/21, at 11:11 a.m. Discussed at interdisciplinary team meeting (IDT): weight 213 lbs. up from 199.4 lbs on 1/23/21. Weight gain was related to better intake and nutrition. -2/1/21, at 2:50 p.m. Resident was independent with eating after set up. Minimal appetite. Took supplement drinks. -2/3/21, at 12:02 p.m. Resident was independent with eating after set up. Minimal appetite. Took supplement drinks. R91's skin assessment dated 1/19/21, identified R91's right lower leg had a dusky discoloration to the area. There was a scabbed area on the left shin and on top of the left foot.	2 830		

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R91's medical record lacked documentation related to his continued weight gain on 2/4/21, as well further skin assessments or monitoring for edema.

During an internal investigation into R91's care, the facility's licensed social worker (LSW) conducted interviews with the nursing staff assisting R91 with daily cares. Of the twenty-one staff interviewed, three nursing assistants were able to identify they had visualized R91's feet during cares, they had provided on three separate occasions. The nursing assistants all reported although edema was noted, the skin was dry and intact. All other staff stated R91 always had his socks on and they had not seen his feet.

R91's medical record indicated he was discharged to an assisted living (AL) on 2/9/21. A telephone nurse report was given to the nurse at the AL, however, the record lacked documentation of what was reported.

During a telephone interview with AL regiseted nurse (RN)-C on 2/18/19, at 10:03 a.m. RN-C indicated R91 arrived on 2/9/21, however, due to findings during his admission assessment, R91 was transferred to the hospital for evaluation. RN-C identified R91's skin on his lower left extremity was red, swollen and an open draining area was noted on top of his left foot. RN-C contacted the LSW of the discharging facility and was told the condition of R91's left lower extremity must have developed in the last five days of his stay at the facility, as no problems were noted on his last bath day on 2/4/21, and there were no orders for wound care.

During telephone interview on 2/18/21, at 10:35 a.m. R91 stated the swelling in his leg had been

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going on for awhile. R91 indicated the nursing staff at the nursing home had looked at his leg but they did not do anything for it.

On 2/18/21, at 12:40 p.m. nursing assistant (NA)-B stated she had given R91 a bath on 2/4/21, and had noted the skin on his lower extremities was dry and intact. NA-B indicated he had some edema but it was not excessive, therefore it was not reported to the nurse.

On 2/18/21, at 1:19 p.m. NA-D stated she recorded resident weights on a chart when she completed the baths. If a resident had a weight gain or loss of 3 pounds or more, she notified the nurse.

During interview on 2/18/21, at 2:47 p.m. with registered nurses (RN)-A and RN-B, RN-B stated residents were weighed weekly and they would only weigh a resident more often if the physician ordered it or if the dietician felt it was needed. If a resident had edema, the staff would assess it as needed. RN-A indicated she read the residents progress notes, events and vital signs out of range each day when she started her shift. R91's weight gain was discussed at IDT on 1/28/21, however the facility did not notify the physician of R91's weight increase. R91 had an internal medicine appointment on 1/28/21, he did not have respiratory distress and the thought was the weight increase was related to improved nutrition, so they did not feel physician notification was needed.

On 2/19/21, at 10:13 a.m. registered dietician (RD) stated she had noted R91's 14 lb. weight gain but had just assumed the weight was inaccurate. The RD indicated she had not requested a re-weigh or documented the weight

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increase in the medical record and the weight discrepancy should have been documented and communicated to nursing staff. The RD stated she had not noticed the subsequent 6 lb. weight gain the following week and she should have addressed it. Typically she would have notified nursing staff and request an assessment. The RD stated the second weight increase must have gotten missed.

On 2/19/21, at 11:40 a.m. the director of nursing (DON) indicated R91's first weight was probably inaccurate as he was resistive to being weighed that day, however a re-weigh was not done. After performing a quick review in R91's electronic hospital record the DON stated the record showed R91's hospital weight on the day of his discharge was 213 pounds. A weight gain of 14 pounds in one week from improved nutrition would be unusual and should be investigated. The DON indicated R91 wore an ankle-foot orthoses (AFO) brace that had a potential risk for skin breakdown and changing R91's socks and inspecting his skin would be an expectation when assisting R91 with his daily care.

The facility's undated policy Prevention and Treatment of Skin Breakdown, indicated maintaining intact skin is integral to resident health and wellness. Skin was observed daily with cares. Weekly skin audits were performed by a licensed nurse.

A policy for monitoring weights for residents was requested, however, none was provided.

SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for monitoring weight loss. Nursing staff could be

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2 830	Continued From page 8 educated as necessary to the importance of monitoring weight loss. The DON or designee, could audit any/all resident's weights and ensure interventions are in place. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: (21) days.	2 830		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced	21535		4/15/21

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21535	Continued From page 9 by: Based on observation, interview and document review, the facility failed to ensure a gradual dose reduction and/or evidence a justification of continued use was obtained for psychotropic (mood altering) medications was for 1 of 3 residents (R13) reviewed who received psychotropic medications. Findings include: R13's annual Minimum Data Set (MDS) dated 2/11/20, indicated R13 had severe cognitive impairment with diagnosie of dementia, and mood disorder. The MDS further indicated R13 had no mood symptoms, psychosis, behavioral symptoms, rejection of care or wandering. The MDS indicated R13 received antipsychotic and antidepressant medications daily and no gradual dose reduction had been attempted. R13's Physician Order Report dated 1/19/21 - 2/19/21, included a physician order for olanzapine (an antipsychotic) 15 milligrams (mg) by mouth one time a day related to an unspecified mood disorder. The order start date was identified as 1/4/19. A physician order for sertraline (antidepressant) 150 mg one time a day related to depression was also listed. The order start date was identified as 1/5/19. R13's care plan dated 12/21/20, indicated R13 was at risk for complication related to olanzapine and sertraline and and intervention included the medical doctor and pharmacy would review per guidelines for gradual dose reductions (GDR). On 2/18/21, at 9:09 a.m. R13 was seated in her wheelchair near the nurses station. R13 was fully dressed and groomed, wearing a surgical face	21535	Corrected	

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mask and her chin was resting on her chest with her eyes closed.

-At 12:21 p.m. R13 was seated in her wheelchair in the dining room, quietly watching people as they passed by.

-At 1:47 p.m. R13 was quietly wheeling her wheelchair about the hall of her wing. An unidentified staff member pushed R13's wheelchair to a nearby table to offer her a snack.

On 2/19/21, at 7:57 a.m. R13 was observed sitting in her wheelchair near the nurses station. R13 was fully dressed and groomed, and was sleeping quietly in her chair. No behaviors were noted.

During interview on 2/18/21, at 7:59 a.m. trained medication aide (TMA)-A stated R13's behaviors were pretty good as she rarely gots mad toward staff and never hit out. TMA-A indicated R13 enjoyed reading and did not bother other residents. R13 did respond well to verbal redirection and giving her a baby doll to hold was another effective intervention.

-At 8:01 a.m. TMA-B stated R13 would get a little aggressive when assisted with personal cares but responded really well to redirection or to leave her for a few minutes and then re-approach. TMA-B stated R13 never bothered other residents and holding a baby doll or her animated plush cat was an effective intervention when she was anxious.

R13's consultant pharmacist's monthly medication reviews identified the following:

- On 10/29/20, please prompt a GDR evaluation on olanzapine and sertraline.

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21535	Continued From page 11 - On 11/25/20, waiting response to 10/20, recommendation to prompt a GDR on both olanzapine and sertraline. - On 12/29/20, have provider document clinical rationale on 8/20, GDR forms for both olanzapine and sertraline. The clinical rationale was not documented. - On 1/25/21, med review complete. GDR forms for both olanzapine and sertraline to be addressed with psychiatric provider at next visit. R13's medical record identified the following regarding R13's psycotropic medications: - On 9/18/19, R13 was seen at neuroscience clinic. The nurse practioner (NP) documented to continue olanzapine as R13 was not a candidate for GDR given history and breakthrough symptoms. However, sertraline was documented to continue med with no GDR evaluation. - On 12/17/19, A Psychopharmacological Medications Tapering Attempt (MTA) form for olanzapine was signed by R13's primary medical doctor (MD). The MD checked no change to current dose with following rationale: needed to maintain residents function and GDR would likely cause resident distress. Decrease or change is likely more harmful to resident than maintaing current dose. However, a sertraline GDR was not addressed. On 11/18/20, The MTA form for olanzapine was signed by R13's primary MD, however, the question is a tapering attempt possible, was not addressed and the clinical rationale lacked any documentation.	21535		

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21535	Continued From page 12 On 11/18/20, The MTA form for sertraline was signed by R13's primary MD, however, the question is a tapering attempt possible, was not addressed and the clinical rationale lacked any documentation. On 12/8/20, A separate MTA form was filled out by nursing for both sertraline and olanzapine, however, the forms did not indicate if a tapering attempt was possible, clinical rationale or physician signature. R13's medical record lacked any documentation of a GDR attempt or clinical rationale of why an attempt could not be made for the year 2020. On 2/19/21, at 8:49 a.m. RN-D stated the nurses had a flow sheet they uses to track when a psychotropic medication was started, when it is up for review and if there was a doctor note completed. The nurses filled out a quarterly evaluation form on psychotropic medications and gave them to the doctor. The doctor scans them back to the facility and they are reviewed by the case manager. If it is not filled out adequately, it is resent to the doctor to complete. R13's psychotropic medications were done by her psychiatric doctor. She was due to be seen in January. During interview on 2/19/21, at 11:29 a.m. the DON stated R13's last psychiatrist visit in September 2019, indicated R13 was not a candidate for reduction. Her primary doctor will not change any psych medications because she was being seen by psychiatry. R13 was unable to be seen by psychiatry due to the covid pandemic. The DON indicated R13's family wanted R13's psychotropic medications continued and there	21535		

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21535	Continued From page 13 was a discussion regarding a psychiatric appointment. The facility was in the process of getting something scheduled. The facility's undated Psychotropic Medication Use policy indicated psychotropic medications were given upon a medical provider order. The nursing associates collaborate with the medical provider to ensure the lowest possible dosage is given for the shortest period of time and are subject to gradual dose reductions and re-review. GDR begins within the first year in which a resident is admitted or newly prescribed a scheduled psychotropic medication. GDR was attempted in two separate quarters, unless clinically contraindicated and documented by the medical provider. The continued use is in accordance with relevant current standards of practice and the medical provider has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy reviews and irregularities. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure pharmacy reviews are timely and irregularities are being acted upon. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21535		

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21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to regularly clean a refrigerated cart which stored food for resident consumption. This had the potential to affect all 40 residents who received meals from the kitchen. Findings include: During observation on 2/19/21, at 9:30 a.m. during follow up kitchen, a Chef Base two drawer refrigerated cart was in use next to the flat top grilling station. Upon opening the top drawer, there were several containers of food (onions, pickles, tomatoes, cheese, and bacon suspended from drawer separators and the bottom of the drawer was open to the rest of the Chef Base refrigerator and food could fall through the drawer. There was old food debris on the drawer separators and on the rail between the two drawers. The bottom drawer had two empty hanging containers in them, and the bottom rail had small pieces of food setting on them. The bottom of the cart and had liquid all over the bottom about 3/8 of an inch deep with what looked like a brown paper towel used to dry your hands in the liquid. The facility's Weekly Cleaning Schedule dated 1/26/21-2/1/21, identified a cleaning schedule for	21665	Corrected	4/15/21

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refrigerators and other equipment in the kitchen; however, did not identify the Chef Base refrigerator.

During interview on 2/19/21, at 9:30 a.m. with the supportive services director (SSD-A), who was in charge of the kitchen, stated they do not know if Chef Base refrigerator had ever been deep cleaned and identified it needed to be. The SSD-A stated the Chef Base refrigerator was not on the regular cleaning schedule.

A request was made for cleaning procedures related to the Chef Base refrigerator, but none was received.

The facility's undated Equipment Operations and Cleaning Procedures indicated the Culinary Services Director was responsible for developing clean procedures for all equipment. Cleaning procedures should be available for each piece of equipment. The Culinary Services Director would instruct employees on cleaning of equipment.

The undated, manufacturer's instructions for the Chef Base refrigerator identified how to conduct regular cleanings. Instruction were included on how to remove components of the drawers for cleaning and instructions on cleaning the inside of the Chef Base refrigerator and ensuring drain is not clogged.

SUGGESTED METHOD OF CORRECTION:
The administrator, dietary supervisor, or designee could ensure a preventative maintenance program was developed to accurately reflect ongoing scheduled cleaning on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform

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21665	Continued From page 16 environmental rounds/audits periodically to ensure cleaning is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has	21980		4/15/21

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21980	Continued From page 17 been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to report allegations of abuse to the State Agency (SA) for 1 of 4 residents (R93) reviewed for abuse. Findings include: R93's quarterly Minimum Data Set (MDS) dated 11/13/20, indicated she had severe cognitive impairment and required extensive assistance for all activities of daily living (ADL)'s. The MDS indicated R93 displayed no behaviors during the assessment period. R93's care plan updated 11/27/20, identified a	21980	Corrected	

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self care deficit and indicated R93 required assistance from two staff for all ADL's along with use of a left arm sling when out of bed.

An untitled facility document dated 8/15/20, written and signed by nursing assistant (NA)-E indicated when checking with R93 on last rounds, R93 stated to NA-E, "don't let [NA-F] take care of me today. The document indicated R93 would not make eye contact with staff when asked "why" she did not want NA-F to take care of her and indicated R93 became teary eyed and stated NA-F was "rough" with her left hand. The issue was reported to the registered nurse (RN) on duty.

A facility document Interview with [R93] dated 8/15/20, indicated licensed social worker (LSW)-A interviewed R93 regarding her telling a staff member that NA-F was rough with her. R93 stated when NA-F turned her it hurt her arm and pointed to her shoulder. LSW-A asked if two people were providing care and R93 stated they usually did. R93 requested a different caregiver but indicated she did not feel NA-F was hurting her on purpose. R93 agreed to having NA-F take care of her if NA-F was educated to "go slower."

A facility document Interview with NA-F dated 8/15/20, indicated LSW-A discussed with NA-F the concern that she had been rough with R93 and hurt her arm when moving her around. LSW-A asked if R93 had ever complained of pain and NA-F stated yes and that she felt bad and tried not to hurt R93. NA-F stated R93 was very protective of her arm.

A staff interview dated 8/19/20, four days after the report, indicated NA-H asked if she had observed anyone hurting R93. NA-H stated "no" but stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 19 R93 had asked to not have NA-F as a caregiver one day, and said "I believe it was Saturday." The staff interview form indicated "please complete and place in [LSW-A] box as soon as possible. A staff interview dated 8/27/20, twelve days after the report, indicated a NA-G stated she had not observed anyone being rough with R93 but stated R93 often talked about a staff member who was rough with her. The staff member further stated R93 talked about NA-F and that R93 would like NA-F to be more gentle and had requested NA-F not wash her up in the morning. The staff interview form indicated "please complete and place in [LSW-A] box as soon as possible. During interview on 2/18/21, at 3:15 p.m., LSW-A stated the allegation of rough treatment had not been reported to the SA. LSW-A stated she did an internal investigation and determined it was not reportable. On 2/19/21, at 8:14 a.m. LSW-A stated she did some further checking into the incident and stated the incident occurred on a Saturday and she went to the facility to talk to R93. LSW-A stated R93 told her "yep, she [NA-F] treats me rough. LSW-A stated R93 said it was more that NA-F moved too fast. LSW-A stated she had already decided it was not abuse and the rest of the staff interviews were "more of a fact check." A facility policy Abuse Prevention Plan dated 2017, indicated all allegations of abuse would be investigated by the director of social services, director of nursing or their designees. Staff were to notify the building charge immediately of any reports of possible abuse, neglect, misappropriation..... The charge would immediately notify the administrator or designee.	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21980	Continued From page 20 The policy directed staff to report allegations of abuse immediately upon receiving a report of possible abuse. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility could re-educate staff identified in the citation to policies and procedures, and audit all complaints of alleged abuse or neglect. The results of those audits could be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**02/17/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE CARE COMMUNITY	**201 9TH STREET WEST** **ADA, MN 56510**

(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 Building 01 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Benedictine Care Community 01 Main Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/15/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**02/17/2021**

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BENEDICTINE CARE COMMUNITY	**201 9TH STREET WEST** **ADA, MN 56510**

(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	Continued From page 1 DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or Or by email to: FM.HC.Inspections@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. The facility was surveyed as two buildings: Benedictine Care Community Bldg. 01 is a 1-story building without a basement. The building was constructed in 2000 and was determined to be of Type I(222) construction. The building is separated from the Hospital Building with a 2-hour fire barrier and the nursing home is divided into 3 smoke compartments with 1-hour fire barriers. The building is fully sprinkler protected with quick response sprinklers and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**02/17/2021**

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BENEDICTINE CARE COMMUNITY	**201 9TH STREET WEST** **ADA, MN 56510**

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K 000	Continued From page 2 The facility has a capacity of 49 beds and had a census of 40 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 133 SS=D	Multiple Occupancies - Construction Type CFR(s): NFPA 101 Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 2 - two hour fire separation was found not in compliance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 7.2.1.15.2, 8.2.1.3 and 19.1.3.4 and NFPA 80 Standard for Fire Doors and Other Opening Protectives section 6.3.1.7.1. These deficient conditions could allow the products of combustion to travel from one building to another, which could	K 133	Maintenance supervisor and maintenance staff were made aware of the issue. The door sweep was fixed and repaired on 2/17/21 in the afternoon. Checking all fire doors will be added to our safety walk Checklist that Leadership does monthly. The safety walk checklist is reviewed at Quality Council monthly. We will review at Quality Council on	4/15/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**02/17/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 133	Continued From page 3 negatively affect 20 of 49 residents located in one smoke compartment. Findings include: On 02/17/2021, at 1:53 p.m. , observations revealed that the 90 minute fire rated double doors located in the 2 hour separation between the care center and the child care / assisted living building had a gap that started at 1/8 of an inch wide at the top of the double doors that expanded to 1/2 of an inch at the lower portion of the doors. This deficient condition was verified by a Maintenance Supervisor.	K 133	04/15/2021. Supportive Service Director, Administrator or designee will do audits monthly that it has been completed on the checklist and will report any issues to Maint Supervisor. Maintenance does a monthly tracer safety walk and will include the fire door inspection. They will report to Administrator with issues or concerns. Administrator will bring to Quality Council monthly. Next meeting is 04/15/21. Will continue the audits per Quality Council.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.	K 353		4/15/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**02/17/2021**

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K 353	Continued From page 4 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available fire sprinkler test and inspection documentation, the automatic sprinkler system is not maintained in accordance with NFPA 25 the Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems 2011 edition section 5.1.1.2. The failure to maintain the sprinkler system in compliance with NFPA 25 (11) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect 49 of 49 residents. Findings include: On 02/17/2021, at 12:50 p.m., during the review of all available fire sprinkler test and inspection documentation and interview with the Maintenance Supervisor it was revealed that the facility did not have the fire sprinkler system annually tested and inspected. The last annual test and inspection was conducted 01/08/2019. The annual fire sprinkler test / inspection should have been completed in January of 2020, prior to the Covid-19 pandemic restrictions on the entry of outside contractors which went into effect in March of 2020. This deficient condition was verified by a Maintenance Supervisor.	K 353	a)Sprinkler system was last checked on 1/29/2020 b)Allied Fire Protection c)Six inch supply line that comes from the City of Ada Municipal water system. The Sprinkler and Maintenance testing has been added to our TELS computer program with Benedictine. This will flag when it is due. Supportive Service Director and Administrator will audit annually to ensure that it is completed. We will add to our safety walk checklist as an annual inspection process. We will bring to Quality Council annually to go over inspection report. Will bring to Quality Council on 04/15/2021. Maintenance Supervisor will audit it annually and email the report to Administrator when completed. Please see attachment for completed inspection on 2/25/2021 and 1/29/2020.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101	K 712		4/15/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**02/17/2021**

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K 712	Continued From page 5 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available fire drill documentation, it was determined that the facility failed to conduct several fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 19.7.1.4 and 19.7.1.6, during the last 12-month period. This deficient practice could affect 49 of 49 residents. Findings include: On 02/17/2021 at 1:15 p.m., during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility did not send a fire alarm signal during the fire drills to the monitoring company for 3 of 12 fire drills. On 02/17/2021 at 1:15 p.m., during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility did not record the the times for all three fire drills conducted in the 4th quarter fire drills.	K 712	Fire Drill schedules from Maintenance will be added to our TELS computer program that will flag when they are due. The Supportive service Director will receive emails on items that are flagged. She will communicate this to Administrator and Maintenance Supervisor for follow-up. Maintenance will utilize a checklist to ensure they send a fire alarm signal to the monitoring company with every drill. Administrator will audit monthly and report to Quality Council monthly starting on 04/15/2021. Maintenance supervisor will add times to every fire drill conducted. Administrator or Supportive service Director will audit the paperwork that times and date are included in all Fire Drills going forward. Administrator or Supportive service Director will report at Quality Council monthly starting on 04/15/21.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**02/17/2021**

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K 712	Continued From page 6 This deficient condition was verified by a Maintenance Supervisor.	K 712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **02 - CHAPEL** B. WING _____	**02/17/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY Building 02 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Benedictine Care Community Bldg. 02 Main Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/15/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **02 - CHAPEL** B. WING _____	**02/17/2021**

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K 000	Continued From page 1 DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or Or by email to: FM.HC.Inspections@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. The facility was surveyed as two buildings: Benedictine Care Community Bldg. 02 is a 1-story building without a basement addition that was constructed in 2013 to the north of the care center and was determined to be of Type V (111) construction. The building is fully sprinkler protected with quick response sprinklers and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 49 beds and had a	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **02 - CHAPEL** B. WING _____	**02/17/2021**

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K 000	Continued From page 2 census of 40 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available fire sprinkler test and inspection documentation, the automatic sprinkler system is not maintained in accordance with NFPA 25 the Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems 2011 edition section 5.1.1.2. The failure to maintain the sprinkler system in compliance with NFPA 25 (11) could allow system being place	K 353	a)Sprinkler system was last checked on 1/29/2020 b)Allied Fire Protection c)Six inch supply line that comes from the City of Ada Municipal water system. The Sprinkler and Maintenance testing has been added to our TELS computer program with Benedictine. This will flag	4/15/21

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	245502	A. BUILDING **02 - CHAPEL** B. WING _____	**02/17/2021**

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BENEDICTINE CARE COMMUNITY	**201 9TH STREET WEST** **ADA, MN 56510**

(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 353	Continued From page 3 out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect 49 of 49 residents. Findings include: On 02/17/2021, at 12:50 p.m., during the review of all available fire sprinkler test and inspection documentation and interview with the Maintenance Supervisor it was revealed that the facility did not have the fire sprinkler system annually tested and inspected. The last annual test and inspection was conducted 01/08/2019. The annual fire sprinkler test / inspection should have been completed in January of 2020, prior to the Covid-19 pandemic restrictions on the entry of outside contractors which went into effect in March of 2020. This deficient condition was verified by a Maintenance Supervisor.	K 353	when it is due and will send an email to our Supportive Service Director. Supportive Service Director and Administrator will audit annually to ensure that it is completed. We will add to our safety walk checklist as an annual inspection process. We will bring to Quality Council annually to go over inspection report. Will bring to Quality Council on 04/15/2021. Maintenance Supervisor during there monthly tracer safety walk will monitor its performance to ensure they are sustained. Will report any issues to Administrator. Please see attachment of Inspection completed on 2/25/2021 and 1/29/2020.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7	K 712		4/15/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **02 - CHAPEL** B. WING _____	**02/17/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE CARE COMMUNITY	**201 9TH STREET WEST** **ADA, MN 56510**

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K 712	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available fire drill documentation, it was determined that the facility failed to conduct several fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section sections 19.7.1.4 and 19.7.1.6, during the last 12-month period. This deficient practice could affect 49 of 49 residents. Findings include: On 02/17/2021 at 1:15 p.m., during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility did not send a fire alarm signal during the fire drills to the monitoring company for 3 of 12 fire drills. On 02/17/2021 at 1:15 p.m., during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility did not record the the times for all three fire drills conducted in the 4th quarter fire drills. This deficient condition was verified by a Maintenance Supervisor.	K 712	Fire Drill schedules from Maintenance will be added to our TELS computer program that will flag when they are due. The Supportive service Director receives emails when items on the list are flagged. She will communicate this to Administrator and she will follow-up with Maintenance Supervisor immediately. Maintenance will utilize a checklist to ensure they send a fire alarm signal to the monitoring company with every drill. Administrator will audit monthly and report to Quality Council monthly starting on 04/15/2021. Maintenance supervisor will add times to every fire drill conducted. Administrator or Supportive service Director will audit the paperwork that times and date are included in all Fire Drills going forward. Administrator or Supportive service Director will report at Quality Council starting on 04/15/21.	