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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 43YI

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 **11/17/2016** (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
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 :
Lyla Burkman, Unit Supervisor 11/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/03/2017 (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
11/22/2016 (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245502

January 3, 2017

Ms. Emmalene Tretter, Administrator
Benedictine Care Community
201 9th Street West
Ada, Minnesota 56510

Dear Ms. Tretter:

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 November 15, 2016 the above facility is certified:

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 Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 21, 2016

Ms.. Emmalene Tretter, Administrator
Benedictine Care Community
201 9th Street West
Ada, Minnesota 56510

RE: Project Number S5502027

Dear Ms.. Tretter:

On October 19, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 6, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), widespread whereby corrections were required.

On November 17, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 17, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 6, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 15, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 6, 2016, effective November 15, 2016 and therefore remedies outlined in our letter to you dated October 19, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.
Feel free to contact me if you have questions related to this letter / eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245502 Y1	A. Building B. Wing Y2	11/17/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241	Correction	ID Prefix F0280	Correction	ID Prefix F0282	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	11/15/2016	LSC	11/15/2016	LSC	11/15/2016
ID Prefix F0312	Correction	ID Prefix F0323	Correction	ID Prefix F0329	Correction
Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(h)	Completed	Reg. # 483.25(l)	Completed
LSC	11/15/2016	LSC	11/15/2016	LSC	11/15/2016
ID Prefix F0334	Correction	ID Prefix F0373	Correction	ID Prefix F0428	Correction
Reg. # 483.25(n)	Completed	Reg. # 483.35(h)	Completed	Reg. # 483.60(c)	Completed
LSC	11/15/2016	LSC	11/15/2016	LSC	11/15/2016
ID Prefix F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/15/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LB/mm	11/21/2016	28035	11/17/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
10/6/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245502 Y1	A. Building 01 - NURSING HOME 01 B. Wing Y2	11/17/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 11/15/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 11/15/2016	ID Prefix Reg. # NFPA 101 LSC K0211	Correction Completed 11/15/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) TL/mm	DATE 11/21/2016	SIGNATURE OF SURVEYOR 36536	DATE 11/17/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/6/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO			

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245502	A. Building 02 - CHAPEL B. Wing	11/17/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 11/15/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 11/15/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) TL/mm	DATE 11/21/2016	SIGNATURE OF SURVEYOR 36536	DATE 11/17/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/6/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Certified Mail # 7013 3020 0001 8869 0763

February 26, 2016

Mr. Tyler Hoemberg, Administrator
Benedictine Care Community
201 9th Street West
Ada, MN 56510

Subject: Benedictine Care Community - IDR
Provider # 245502
Project # S5502026

Dear Mr. Hoemberg:

This is in response to your letter of December 16, 2015, in regard to your request for an informal dispute resolution (IDR) for the federal deficiency issued at tag F314 S/S-G 483.25(c) issued pursuant to the survey event 6OS711, completed on November 25, 2015.

The information presented with your letter, information gleaned from your staff during our telephone conversation, the CMS 2567 dated November 25, 2015 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F**314 S/S-(G) 42 CFR § 483.25(c) : Pressure Sores-Based on the comprehensive assessment of a resident, the facility must ensure that (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.**

Summary of the facility's reason for IDR of this tag: The facility disputed the findings based on their assertions that staff had appropriately implemented the following: an individualized plan of care, appropriate treatment, and prevented the resident from developing an infection. The facility also asserted the identified pressure ulcers were unavoidable due to the resident's severe vascular disease, and indicated the resident would continue to develop ulcerations despite nursing staff making every attempt to prevent them.

Summary of findings: R13 was at high risk for pressure ulcer development based on past history of pressure ulcers, venous and arterial ulcers and numerous co-morbidities. R13 had a pressure ulcer located on the buttock identified on 8/27/15, which was healed on 10/16/15, with subsequent revision of the plan of care, including hourly repositioning and the application of protective skin creams. The licensed practical nurse (LPN) then documented in the medical record on both 11/12/15, and 11/20/15, that R13 had "one open area on the buttock." However, there was no comprehensive reassessment documented, nor was the location, measurement and/or stage of the wound(s) identified. In addition, evidence was lacking to indicate whether incontinence-associated dermatitis (IAD) had contributed to this skin condition, and/or whether alternative

interventions were necessary to prevent or reduce the risk of further pressure ulcer development. The facility had conducted a Tissue Tolerance assessment 11/18/15 which revealed skin coloration was unchanged when R13 remained seated in the chair and/or lying in bed for two hours. There was no analysis documented related to the open areas identified on 11/12/15 and 11/20/15.

The facility submitted documentation from their Matrixcare (electronic health record). Documentation from 11:12 a.m. on 11/24/15, indicated the registered nurse (RN) had readjusted R13's repositioning schedule from every two hours to hourly following an observation with the MDH surveyor at 8:03 a.m. that morning when the two open areas were observed on the buttock. The RNs documentation indicated the resident had two open areas on the buttocks which measured: right- 0.5 cm (centimeters) x 0.6 cm and left- 0.6 cm x 0.7 cm.

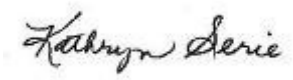
The facility's Turning and Repositioning policy was also reviewed and indicated, "if a resident's skin is impaired related to a pressure ulcer, and once the area had healed, the resident would remain on a turning and repositioning shchedule of one hour for six months." The plan of care and staff interview confirmed R13 had been maintained on a two hour repositioning schedule after the pressure ulcer identified on 8/27/15, was healed on 10/16/15. Staff did not reassess the conditions surrounding the recurrent open area identified on 11/12/15 and 11/20/15, and failed to implement and maintain the hourly repositioning schedule for six months per their own policy. A comprehensive reassessment was not evident when newly developed open areas were noted on R13's buttock, who experienced recurrent ulcers. In addition, the facility lacked evidence of an assessment determining whether the identified areas were avoidable vs. unavoidable until 12/7/15, after survey.

This is a valid deficiency at this tag and at the correct scope and severity of a G.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,



Kathryn M. Serie, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 507-476-4233 Fax: 507-537-7194

cc: Office of Ombudsman for Long-Term Care
Pam Kerssen, Assistant Program Manager
Licensing and Certification File
Lyla Burkman , Bemidji District Office Unit Supervisor

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

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ID: 43YI

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(L4) **201 9TH STREET WEST**
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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 **10/06/2016** (L34)

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0 Unaccredited 1 TJC
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7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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FISCAL YEAR ENDING DATE: (L35)
06/30

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From (a) :
To (b) :

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A. In Compliance With Program Requirements Compliance Based On:
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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 :
Lisa Carey, HFE NEII 11/03/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/22/2016 (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
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21. 1. Statement of Financial Solvency (HCFA-2572)
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25. LTC EXTENSION DATE:
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A. Suspension of Admissions:
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B. Rescind Suspension Date:
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01-Merger, Closure
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05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

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(L28)

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00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 19, 2016

Ms. Emmalene Tretter, Administrator
Benedictine Care Community
201 9th Street West
Ada, Minnesota 56510

RE: Project Number S5502027

Dear Ms. Tretter:

On October 6, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 15, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 15, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 6, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 6, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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 _____	10/06/2016

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	INITIAL COMMENTS 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 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 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents seated at the same dining table were served and/or provided assistance to eat at the same time as their tablemate's during 3 of 5 meals observed which affected 5 of 5 residents (R13, R17, R32, R47,R22) who were observed to not be provided a dignified dining experience. Findings include:	F 241	R13, R17, R32, R47 and R22 will be served their meals and eat at same time as tablemates. C.N.A.'s will not bring in assist table residents until they can go into the dining room to assist them. All residents will receive meals at the same times as their tablemates. Facility will develop a new dining room policy. Dining room has separated tables so not more than 4 residents can sit at a table at a time. All staff will be educated on 11/15/2016 on this process.	11/15/16

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

Electronically Signed | 10/31/2016

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F 241	Continued From page 1 R13's quarterly Minimum Data Set (MDS) dated 8/12/16, indicated R13 was diagnosed with dementia, had severe cognitive impairment and required total assistance of one staff for eating. The MDS also indicated R13 required a mechanically altered diet. R13's care plan dated 8/26/16, directed the staff to provide and serve a pureed diet as ordered and to provide assistance of one to eat. The plan indicated R13 required adaptive cups ("nosey cups") for liquids and occasionally pocketed food in her mouth and would not swallow. The plan indicated some meals went well without problems and the next meals R13 would not remember or understand how to swallow. R47's quarterly MDS dated 7/15/16, indicated R47 was diagnosed with dementia, had cognitive impairment, was able to eat independently and required a therapeutic diet. R47's care plan dated 5/4/16, indicated R47 was able to eat a regular diet with cues from staff members. R32's quarterly MDS dated 9/9/16, indicated R32 was diagnosed with dementia, had cognitive impairment, required a mechanically altered diet and required total assistance from to eat. R32's care plan dated 5/11/15, indicated R32 was on a mechanically soft diet and required assist of	F 241	DON/designee will audit daily the time the residents need to wait at meals and if they are served at same time. In-time training will occur immediately upon identification of protocol compliance lapse. These items will be reviewed at QC on 11/15/2016. Analysis of the observations/audits and facilities compliance will be presented to our Quality Assurance Team and approved by the Administrator. The quality Assurance Team will implement needed changes and determine the need for on-going monitoring/auditing after analysis. The facility will be in compliance by 11/15/2016	

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F 241	Continued From page 2 one for eating. R22's quarterly MDS dated 9/16/16, indicated R22 was diagnosed with dementia and aphasia (impaired ability to speak), had severed cognitive impairment and required extensive assistance with eating. The MDS also indicated R22 had difficult eating a mechanically altered diet and displayed loss of liquids and solids from her mouth when eating. R22's care plan dated 10/3/16, indicated R22 required a pureed diet with nectar thickened liquids. The plan directed the staff to assist R22 to eat slowly. R17's quarterly MDS dated 8/2/16, indicated R17 was diagnosed with dementia and anxiety, displayed severe cognitive impairment, required a mechanically altered diet and extensive assistance of one staff for eating. R17's care plan dated 8/26/16, indicated R17 required a regular diet with ground meat and assist of one for eating. On 10/3/16, at 4:43 p.m. R13, R47, R32, R22, and R17 were observed seated at a dining room table in the main dining room. Activity assistant (AA)-A was observed to be seated between R32 and R22. AA-A fed R32 her meal while R13, R47, R22, and R17 sat at the table without their meals. - At 4:51 p.m. AA-A stopped assisting R32 and	F 241		

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F 241	Continued From page 3	F 241		

walked over to R13 and gave her a few sips of milk. She then returned to R32. At that time the assistant administrator approached AA-A and asked her if she needed assistance. AA-A stated no assistance was was required at that time. The assistant administrator, then left the dining room table.

- At 4:55 p.m. AA-A continued to feed R32 while the other four residents at the table waited for their meals to be served.

- At 4:58 p.m. R13 was served a meal consisting of pureed meat, vegetable and desert. AA-A positioned herself in between R13 and R32 and began feeding the two residents. At that time nursing assistant (NA)-B joined the dining room table and began feeding R22. R17 and R47 had not been served their meals.

- At 5:05 p.m. AA-A informed R32 that a different staff member would assist her with the meal. At that time NA-A sat down at the table in between R17 and R32. NA-A began to feed R32 her meal.

- At 5:07 p.m. R17 was served her meal. NA-A fed R17 and R32. R47 waited for the meal while the other four residents at her table were assisted with the evening meal.

- At 5:10 p.m. R47 was served her meal 20 minutes after the first resident had been served at her table. R47 was observed to receive cues from NA-A to eat the meal.

- At 5:42 p.m. AA-A verified R47 and R17 were seated at the table when she began assisting R32 with the evening meal, yet R47 and R17

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F 241	Continued From page 4	F 241		

were not served the meal and assisted with their meals timely. She verified R47 and R17 waited up to 20 minutes to receive the meal after their tablemate's had been served.

On 10/4/16, at 11:40 a.m. the noon meal was observed in the main dining room. R22, R17 and R47 were observed seated in the dining room. R22 was observed to have her meal in front of her and was receiving assistance from a hospice NA to eat the meal. No staff members were observed present to assist R47 or R17 with their meals.

- At 11:48 a.m. R47 received her meal. R47 began eating the meal independently. R17 joined the table.

- At 11:56 a.m. NA-B sat down next to R13 to assist her with the meal. At 12:00 p.m. a dietary staff member served R13 the noon meal. R17 had not received the noon meal while R13, R47, R22 ate their meal at the table.

- At 12:10 p.m. the hospice NA wheeled R22 out of the dining room as she was done with the meal. R17 was then served her meal. R17 sat at the dining room table a total of 20 minutes without being served or assisted with her noon meal as her tablemate's were assisted.

- At 12:30 p.m. NA-B stated the staff tried to feed the residents on a one to one basis and sometimes that meant that the other residents at the table needed to wait before they could be assisted. She verified R17 had to wait before being assisted with the evening meal.

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F 241	Continued From page 5 On 10/4/16, at 4:40 p.m. the evening meal was observed in the main dining room. R17, R22, R47, R32 and R13 were observed seated at the dining room table waiting for their meal to be served. NA-D and NA-C were observed to join the table. - At 4:52 p.m. NA-D stated she was ready to assist R22 and R13. - At 4:56 p.m. all of the residents at the table received their meals. NA-D began to assist R22 with her meal but did not attempt to assist R13. R47 began to eat her meal independently as NA-E assisted R17 and R32 with their meals. - At 5:10 p.m. NA-D finished assisting R22 her meal and assisted her out of the dining room. - At 5:15 p.m. NA-D turned to R13 and began assisting her with the meal. R13 had sat in the dining room with her food in front of her for 19 minutes and had not received assistance with the meal. On 10/5/16, at 1:10 p.m. registered nurse (RN)-A stated the facility did not have a written timeframe as to how quickly residents at the same dining room table received their meals. She stated she would expect the meals to be served within 5-10 minutes of each other. She confirmed having to wait 20 minutes after your tablemate's had been served the meal was not dignified. On 10/5/16, at 1:46 p.m. the director of nursing (DON) stated residents who were present at the dining room, were to receive their meals and assistance at the same time. She stated the residents should not have to wait up to 20	F 241		

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F 241	Continued From page 6 minutes to receive assistance with their meal especially if their meal was in front of them. She verified the residents had not been served in a dignified manner. The Feeding- Resident policy dated 11/2009, directed the staff to assist a resident who did not have the ability to feed themselves. The policy did not direct the staff to ensure the residents seated at the same table received timely and dignified assistance with the meal.	F 241		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280		11/15/16

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F 280	Continued From page 7 by: Based on observation, interview and document review, the facility failed to revise the care plan to include speech therapy safe eating recommendations in order to decrease/prevent the risk for choking and/or aspiration for 1 of 1 resident (R5) reviewed for eating assistance who had speech therapy recommendations which were not included in the care plan. Findings include: R5's quarterly MDS dated 8/26/16, indicated R5 had severe cognitive impairment, required extensive assist from two staff for bed mobility and extensive assist from one staff for eating, did not have any swallowing problems and required a mechanical altered diet. In addition, the MDS indicated no behaviors. R5's cognition care plan last revised on 10/4/16, indicated R5 had short term memory problems and temporal orientation problems related to dementia. The psychosocial care plan last revised on 10/4/16, indicated R5 had a history of not wanting to get out of bed and social isolation. R5's nutrition care plan last revised on 9/7/16, alerted staff R5 had inadequate oral intake related to refusing to eat and drink at most meals and directed staff to provide with mechanical soft nectar thick liquid diet. R5's eating care plan last revised on 10/4/16, indicated R5 was independent to extensive assist of one staff, depending on the day. R5 occasionally ate in her room when refused to get up. Staff were directed to encourage R5 to get out of bed for meals to prevent any swallowing issues which R5 had refused to have staff assist her with eating in	F 280	R5 care plan will be updated to include that the resident will be assisted with all meals including those in her room. All resi9dents that are at the assist table in the dining room will have assistance in their rooms. DON/designee will audit that all residents who receive assistance in the dining room will have assistance in their4 rooms and it will be documented in their plan of care. All staff will be educated on 11/15/2016 and audits will be presented too Quality Council on 11/15/2016. Analysis of the observations/audits and facilities compliance will be presented to our Quality Assurance Team and approved by the Administrator. The Quality Assurance Team will implement need3ed changes and determine the need for on-going monitoring/auditing after analysis. The facility will be in compliance by 11/15/2016	

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F 280	Continued From page 8	F 280		

which R5 had been educated on the risks of aspiration if she was not supervised or assisted. The plan indicated if R5 refused to get out of bed, staff were to assist her to sit up at 60-90 degree angle for all meals, get her food and drink close to her and provide supervision during meal. If R5 did get up, she ate in the dining room with supervision/assistance. R5 would allow staff to assist her with thickened water when in bed at night.

The undated Nursing Assistant Sheet directed staff R5 required mechanical soft diet with ground meats with nectar thick liquids and was assist of one staff to eat. No indication of supervision required identified.

R5's most recent speech evaluation form dated 12/22/15, revealed an informal bedside swallow test was completed. The form indicated R5 had a history of suspected aspiration pneumonia (no date given) and does not have any family near. The speech therapist report indicated R5 had a 1-10% mandibular function impairment, 10-25% impairment of sensation of oral pharynx with risk of trace aspiration, 10-25% impairment of formation of bolus with risk of trace aspiration, and mild swallow initiation delay of 3-5 seconds. The visit note indicated R5 was somewhat responsive to cueing and was not able to follow directions appropriately without maximum verbal cues being given. The speech therapist recommendations indicated R5 required supervision for meals if she ate in her room, otherwise, required to have meals in the dining area where there was help present. R5 could be independent in eating, however needed to have someone present to remind her of taking small bites and chewing them appropriately and to also

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take smaller sips of her drinks. R5's positioning needed to be at least 45 degrees or more upright when eating or drinking. With R5 being positioned lying to far back, she was at a higher risk for aspiration. R5 also tips to the side throughout the meal which may be due to her poor strength and ability to stay upright. However, for safety in swallowing, R5 needs to remain upright. The speech therapist also recommended a diet change from regular to mechanical soft with ground meats and nectar thickened liquid. R5's care plan lacked the speech therapist's recommended compensatory measures to reduce the risk of aspiration which included verbal cues of taking small bites and chewing, take small sips, and ensure sitting up straight in her wheelchair.

R5's current electronic physician orders printed and provided by the facility on 10/6/16, included a diet order which indicated a mechanical soft with ground meats. Nectar thick liquids. Cool down technique for hot liquids. Nosey cups for meals.

On 10/4/2016, at 10:51 a.m. R5 was observed lying in bed with her eyes closed. The head of the bed was elevated to approximately 45 degrees. The overbed tray table was positioned over her midline. On top of the table within easy reach were two full glasses of what appeared to be nectar thick milk. On top of the bedside night stand was a glass of what appeared to be nectar thick cranberry juice which was not within in easy reach of R5 while she was lying in bed.

On 10/5/16, at 11:27 a.m. nursing assistant (NA)-I was observed assisting R5 with morning cares.

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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
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NA-I stated R5 had refused her breakfast this morning and was willing to get up now. There was a glass of what appeared to be nectar thick cranberry juice on the bedside table.

-At 11:51 a.m. R5 was observed seated in her wheelchair at the dining room table. R5 was leaning to her left side while in the chair. NA-J sat next to her. When asked, NA-J stated R5 required verbal cues to eat because she often fell asleep during the meal and needed thickened liquids because she had problems swallowing. NA-J verified she had heard R5 cough a couple of times when eating/drinking but more so when she seemed to be tired and was able to clear it herself. NA-J stated R5 was "pretty often" tired and required supervision when drinking.

-At 12:00 p.m. R5 was observed to independently take small continuous sips of milk and did not immediately swallow the fluid. Once she swallowed, she took another drink held it in her mouth for a second and began to chew the fluid and again held the fluid in her mouth for 2 seconds prior to swallowing.

-At 12:02 p.m. R5 took another drink of liquid, chewed the liquid then swallowed. R5 then started to cough. The cough was wet sounding, sputtering, and shallow or weak. Even though R5 was coughing she continued to take sips of her milk. NA-J stood up and moved closer to R5 and asked if she was ok. R5 was still coughing with milk running out of the left side of her mouth.

-At 12:04 p.m. NA-J gave R5 a bite of food in which R5 swallowed the food and coughed twice. The cough sounded dry.

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F 280	Continued From page 11 Between 11:51 a.m. and 12:04 p.m. a licensed nurse was not observed to be in the area of the dining room where R5 was sitting. -At 12:06 p.m. R5 continued to chew the food that was in her mouth at 12:04 p.m. At this time, NA-J gave R5 another bite of food, R5 did not swallow the bite for over 3 minutes. -At 12:11 p.m. R5 took a drink of milk and started coughing, she again continued to take a drink until NA-J intervened. The cough sounded wet and productive. NA-J did not provide verbal cues or compensatory measures throughout the observation and nursing progress notes had not included documentation and/or assessment of the coughing spells after drinking fluids. -At 12:26 p.m. speech therapist (ST)-A stated if a resident had the need for thickened liquids, the need for supervision was based off of cognition, but usually we recommended supervision. ST-A retrieved R5's last speech evaluation notes and stated R5 should not be left alone in her room with fluids in front of her which had been the concern before. ST-A stated speech therapy had given recommendations that R5 needed to have supervision if she was going to eat in her room. -At 3:02 p.m. R5 was observed lying in bed with her eyes closed. The glass with thickened red fluid in it had been removed from the bedside table and replaced with a closed sealed container of nectar thickened liquid. The container was out of R5's reach while she was lying in bed. On 10/6/16, at 8:26 a.m. NA-C stated R5 required	F 280		

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assistance to eat and staff encouraged her to get up for meals. NA-C stated if R5 does not get out of bed, then her fluids should not be left in front of her since she needs assistance.

-At 9:16 a.m. registered nurse (RN)-B explained thickened liquids were left in R5's room on the bedside table so it would prompt staff to offer fluids, "hydrate in and hydrate out." RN-B indicated it was easier to have the thickened liquids on the bedside table. RN-B stated if a resident was coughing on an item for three times, the item should be taken away and the nurse should be notified but if a resident was just coughing to clear then we don't necessarily say that needs to be reported.

-At 11:02 a.m. director of nursing (DON) indicated if a resident needs assistance and they eat in their room then the tray should go to the nurse. The nurse would then make the determination at the time if they are able to eat alone.

The undated facility Care Plans policy indicated all residents would have a comprehensive care plan that included measurable objectives and timetables to meet a residents medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment. The plan would describe the services that were to be furnished in order to attain and maintain the resident's highest practicable physical, mental and psychosocial well-being. Nursing Assistant Resident Care Plan, an abbreviated resident care plan would be given to the nursing assistants to cover the residents' captivities of daily living needs. The plans would be written for intervention regarding the residents' activities of daily living on

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F 280	Continued From page 13 admission and updated weekly, and/or with significant changes, and/or with hospital returns. Updates and revisions were also to be made on the electronic care plan of each resident. All changes were to be dated.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide transfer assistance as directed by the care plan for 1 of 2 residents (R33) reviewed for accidents and who required a mechanical lift for transfers. In addition the facility failed to provide supervision and appropriate bed height elevation for eating/drinking as directed by the care plan for 1 of 1 resident (R5) reviewed for eating. Findings included: R33 was not provided the use of a PAL lift for transfers, as directed by the care plan. R33's Face Sheet indicated R33 was diagnosed with generalized muscle weakness, difficulty in walking, generalized edema, and osteoporosis. R33's functional range of motion care plan last revised on 10/3/16, indicated R33 had decreased range of motion (ROM) in the right shoulder, right	F 282	R 33 will have the PAL lift and A02 for all transfers. R33 had a physical therapy evaluation. R5 will have the appropriate height for eating and drinking. All residents will have appropriate transfers that are following their plan of care. All residents will have supervision and appropriate supervision and table height according to their plan of care. DON/designees will daily audit for appropriate supervision and table height with meals daily. Employee coaching with NA-G was held on 10/06/2016. All staff will be educated on 11/14/2016 and audits will be brought to QC on 11/15/2016. Analysis of the observations/audits and facilities compliance will be presented to our Quality assurance Team and approved by the administrator. The Quality assurance Team will implement needed changes and determine the need for on-going monitoring/auditing after	11/15/16

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F 282	Continued From page 14 knee, and hip related to arthritis, obesity and muscle weakness with an increased need for assistance for transferring and also increased discomfort with movement of extremities. R33's care plan directed staff to provide assistance with mobility as needed to reduce pain and prevent falls and to utilize a PAL lift (mechanical lift used to assist resident to come to a standing position for transfers) as ordered, and a wheelchair. However, R33's care plan for toileting last revised on 10/4/16, directed staff to use the PAL lift with assist from two staff members or may use assist of one, if trying to self- transfer." R33's undated Nursing Assistant Sheet directed staff that R33 required assist of two staff members with the PAL lift for toileting and transfers, however may use assistance of one staff if R33 was starting to self-transfer which was hand written on the sheet with no start/stop date indicated. The sheet listed a gait belt, wheelchair, and PAL lift as the assistive devices required for R33. A progress note dated 9/29/16, indicated R33 continued to be hard to transfer with gait belt and also had trouble standing due to not being able to bend her knees or pick her feet up to pivot. On 10/4/16, at 3:37 p.m. R33's bathroom call light was on, nursing assistant (NA)-G was observed to enter the bathroom. R33 was sitting calmly in her wheelchair in the bathroom in front of the toilet. R33 informed NA-G she needed to use the restroom. NA-G directed R33 to use the grab bars to stand up. R33 used her left arm to reach for the grab bar; once R33 had a hold of the grab bar and started to attempt to pull up, she made facial grimaces and reported pain in her left	F 282	analysis. The facility will be in compliance by 11/15/2016	

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F 282	Continued From page 15	F 282		

shoulder. NA-G advised R33 to take her time and attempt again. R33 made another attempt while NA-G stood on her right side with her arm laced under R33's right arm. R33 lifted off the chair slightly, and sat back down. Another attempt was made in this fashion and R33 came to a standing position. R33 was not steady once in a standing position and required NA-G's assistance to keep her balance. NA-G asked R33 which way she would like to turn. R33 stated she wanted to turn towards her (counterclockwise). NA-G provided verbal cues on hand placement while turning. R33 used the wheelchair arms for support, the chair arms were shaking under the weight. While turning, R33 was not balanced and her lower extremities appeared weak as if knees were going to give out; R33 required constant verbal cues to complete the transfer. When R33 sat on the toilet, she was not straight and sitting more towards the left side. No gait belt was used for the transfer.

-At 3:47 p.m. R33 was finished in the restroom. NA-G and NA-H entered the room with a PAL lift. The NA's transferred R33 from the toilet back to her wheelchair. R33 did not report pain and did not display non-verbal signs of discomfort during the transfer.

-At 3:50 p.m. R33 stated, "the lift is very helpful because it helps relieve the pain in my shoulder."

-At 3:54 p.m. NA-G was asked why the lift had not been used to transfer R33. NA-G stated in the morning staff were not using the lift, however, had seen NA-H bring a lift in to the room so NA-G guessed it was because sometimes in the morning R33 utilized the lift because she was harder to transfer and in the afternoon they did

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not use the lift because R33 transferred better.

-At 3:57 p.m. R33 was asked when staff used the lift to transfer her, R33 stated sometimes they used it, but not all the time. R33 stated she did not tell staff when to use it rather, they use it when they want too. R33 also stated during the last few months it was more difficult to transfer because of her arthritis and preferred using the lift.

On 10/5/16, at 8:06 a.m. NA-I indicated R33 required the lift with assist of two staff members. NA-F confirmed this and stated the use of the Pal lift was just recently implemented because R33 was struggling with transfers and tolerated the lift better with no complaints of pain. NA-F also stated some staff may not know that yet because it was just changed.

On 10/6/2016, at 8:46 a.m. registered nurse (RN)-B explained R33 had showed a decline in mobility within the last month of September. RN-B stated R33 required a lift because she was at risk for falling, but if she was attempting to self-transfer she could be assisted with one to prevent falling. RN-B stated she expected staff to follow the care plan.

R5 was not provided appropriate elevation and supervision with eating/drinking as directed by the care plan.

R5's eating care plan last revised on 10/4/16, indicated R5's ability to eat varied from independent to requiring extensive staff assistance to eat day to day. The plan also indicated R5 would occasionally refuse to get up therefore would eat in her room/bed and also

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F 282	Continued From page 17 refused staff assistance to eat. The plan indicated R5 was educated on the risks of aspiration if not supervised or assisted to eat. The plan directed staff to encourage R5 to get out of bed for meals to prevent any swallowing issues and if R5 refused to get out of bed, staff were to assist R33 to sit up at 60-90 degree angle while eating, place her food and drink close to her and provide supervision of one staff during the meal. If R5 got up for meals, she ate in the dining room with supervision/assistance. R5 would allow staff to assist her with thickened water when in bed at night. On 10/4/2016, at 10:51 a.m. R5 was observed lying in bed with her eyes closed with the head of the bed elevated to approximately 45 degrees. The overbed tray table was positioned over her midline. On top of the table and within easy reach were two full glasses of what appeared to be nectar thick milk. On 10/5/16, at 11:51 a.m. NA-J stated R5 required verbal cues when eating because she often fell asleep during the meal and needed thickened fluids because she had problems swallowing. NA-J confirmed R5 required supervision when drinking. -At 12:26 p.m. the speech therapist (ST)-A explained if someone had the need for thickened liquid the need for supervision is based off of cognition, but usually we recommend supervision. ST-A retrieved the last speech evaluation notes and confirmed R5 should not be left alone in her room with fluids in front of her therefore the speech therapist gave recommendations she needed to have supervision if R5 was going to eat in her room.	F 282		

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F 282	Continued From page 18 On 10/6/16, at 8:26 a.m., NA-C confirmed R5 required assistance to eat and staff encouraged her to get up for meals. NA-C stated if R5 chose not to get out of bed for meals, fluids should not be left in front of her since she needed assistance. At 11:02 a.m. director of nursing (DON) indicated if R5 required assistance to eat, and she ate in her room, the meal tray should go to the nurse at which time the nurse would make the determination if the resident was able to eat alone. The undated facility Care Plans policy indicated all residents would have a comprehensive care plan that would include measurable objectives and timetables to meet a residents medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment. The plan would describe the services that were to be furnished in order to attain and maintain the resident's highest practicable physical, mental and psychosocial well-being.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312		11/15/16

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F 312	Continued From page 19 Based on observation, interview and document review, the facility failed to provide supervision while eating/drinking as recommended by the speech therapist for safe eating in order to decrease/prevent the risk for choking and/or aspiration for 1 of 1 resident (R5) who required supervision/assistance with eating due to aspiration risk and was observed not to be provided it. Findings include: R5's quarterly MDS dated 8/26/16, indicated R5 had severe cognitive impairment, required extensive assist from two staff for bed mobility and extensive assist from one staff for eating, did not have any swallowing problems and required a mechanical altered diet. In addition, the MDS indicated no behaviors. R5's Nutrition CAA dated 3/1/16, indicated R5 had frequent refusals of meals, mechanical soft diet with nectar thickened liquids, no problems with chewing or swallowing noted, and required extensive assistance from one staff for eating. R5's cognition care plan last revised on 10/4/16, indicated R5 had short term memory problems and temporal orientation problems related to dementia. The psychosocial care plan last revised on 10/4/16, indicated R5 had a history of not wanting to get out of bed and social isolation. R5's nutrition care plan last revised on 9/7/16, alerted staff R5 had inadequate oral intake related to refusing to eat and drink at most meals and directed staff to provide with mechanical soft nectar thick liquid diet. R5's eating care plan last	F 312	R 5 will receive supervision/assistance with all meals including those in her room. All residents at the assist table in the dining room will have assistance in their rooms. All residents that require supervision with intake must not have food/beverage items within reach. DON/designee will daily audit that all residents who receive assistance in the dining room will have assistance in their rooms. All staff will be educated on 11/15/2016 and audits brought to QC on 11/15/2016. Analysis of the observation/audits and facilities compliance will be presented to our Quality Assurance Team and approved by the Administrator. The Quality Assurance team will implement needed changes and determine the need for on-going monitoring/auditing after analysis. The facility will be in compliance on 11/15/2016.	

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revised on 10/4/16, indicated R5 was independent to extensive assist of one staff, depending on the day. R5 occasionally ate in her room when refused to get up. Staff were directed to encourage R5 to get out of bed for meals to prevent any swallowing issues which R5 had refused to have staff assist her with eating in which R5 had been educated on the risks of aspiration if she was not supervised or assisted. The plan indicated if R5 refused to get out of bed, staff were to assist her to sit up at 60-90 degree angle for all meals, get her food and drink close to her and provide supervision during meal. If R5 did get up, she ate in the dining room with supervision/assistance. R5 would allow staff to assist her with thickened water when in bed at night.

The undated Nursing Assistant Sheet directed staff R5 required mechanical soft diet with ground meats with nectar thick liquids and was assist of one staff to eat. No indication of supervision required.

R5's most recent speech evaluation form dated 12/22/15, revealed an informal bedside swallow test was completed. The form indicated R5 had a history of suspected aspiration pneumonia (no date given) and does not have any family near. The speech therapist report indicated R5 had a 1-10% mandibular function impairment, 10-25% impairment of sensation of oral pharynx with risk of trace aspiration, 10-25% impairment of formation of bolus with risk of trace aspiration, and mild swallow initiation delay of 3-5 seconds. The visit note indicated R5 was somewhat responsive to cueing and was not able to follow directions appropriately without maximum verbal cues being given. The speech therapist

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recommendations indicated R5 required supervision for meals if she ate in her room, otherwise, required to have meals in the dining area where there was help present. R5 could be independent in eating, however needed to have someone present to remind her of taking small bites and chewing them appropriately and to also take smaller sips of her drinks. R5's positioning needed to be at least 45 degrees or more upright when eating or drinking. With R5 being positioned lying to far back, she was at a higher risk for aspiration. R5 also tips to the side throughout the meal which may be due to her poor strength and ability to stay upright. However, for safety in swallowing, R5 needs to remain upright. The speech therapist also recommended a diet change from regular to mechanical soft with ground meats and nectar thickened liquid. R5's care plan lacked the speech therapist's recommended compensatory measures to reduce the risk of aspiration which included verbal cues of taking small bites and chewing, take small sips, and ensure sitting up straight in her wheelchair.

R5's current electronic physician orders printed and provided by the facility on 10/6/16, included a diet order which indicated a mechanical soft with ground meats. Nectar thick liquids. Cool down technique for hot liquids. Nosey cups for meals.

On 10/4/2016, at 10:51 a.m. R5 was observed lying in bed with her eyes closed. The head of the bed was elevated to approximately 45 degrees. The overbed tray table was positioned over her midline. On top of the table within easy reach were two full glasses of what appeared to be nectar thick milk. On top of the bedside night

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stand was a glass of what appeared to be nectar thick cranberry juice which was not within in easy reach of R5 while she was lying in bed.

On 10/5/16, at 11:27 a.m. nursing assistant (NA)-I was observed assisting R5 with morning cares. NA-I stated R5 had refused her breakfast this morning and was willing to get up now. There was a glass of what appeared to be nectar thick cranberry juice on the bedside table.

-At 11:51 a.m. R5 was observed seated in her wheelchair at the dining room table. R5 was leaning to her left side while in the chair. NA-J sat next to her. When asked, NA-J stated R5 required verbal cues to eat because she often fell asleep during the meal and needed thickened liquids because she had problems swallowing. NA-J verified she had heard R5 cough a couple of times when eating/drinking but more so when she seemed to be tired and was able to clear it herself. NA-J stated R5 was "pretty often" tired and required supervision when drinking.

-At 12:00 p.m. R5 was observed to independently take small continuous sips of milk and did not immediately swallow the fluid. Once she swallowed, she took another drink held it in her mouth for a second and began to chew the fluid and again held the fluid in her mouth for 2 seconds prior to swallowing.

-At 12:02 p.m. R5 took another drink of liquid, chewed the liquid then swallowed. R5 then started to cough. The cough was wet sounding, sputtering, and shallow or weak. Even though R5 was coughing she continued to take sips of her milk. NA-J stood up and moved closer to R5 and asked if she was ok. R5 was still coughing with

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milk running out of the left side of her mouth.

-At 12:04 p.m. NA-J gave R5 a bite of food in which R5 swallowed the food and coughed twice. The cough sounded dry.

Between 11:51 a.m. and 12:04 p.m. a licensed nurse was not observed to be in the area of the dining room where R5 was sitting.

-At 12:06 p.m. R5 continued to chew the food that was in her mouth at 12:04 p.m. At this time, NA-J gave R5 another bite of food, R5 did not swallow the bite for over 3 minutes.

-At 12:11 p.m. R5 took a drink of milk and started coughing, she again continued to take a drink until NA-J intervened. The cough sounded wet and productive.

NA-J did not provide verbal cues or compensatory measures throughout the observation and nursing progress notes had not included documentation and/or assessment of the coughing spells after drinking fluids.

-At 12:26 p.m. speech therapist (ST)-A stated if a resident had the need for thickened liquids, the need for supervision was based off of cognition, but usually we recommended supervision. ST-A retrieved R5's last speech evaluation notes and stated R5 should not be left alone in her room with fluids in front of her which had been the concern before. ST-A stated speech therapy had given recommendations that R5 needed to have supervision if she was going to eat in her room.

-At 3:02 p.m. R5 was observed lying in bed with her eyes closed. The glass with thickened red

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fluid in it had been removed from the bedside table and replaced with a closed sealed container of nectar thickened liquid. The container was out of R5's reach while she was lying in bed.

On 10/6/16, at 8:26 a.m. NA-C stated R5 required assistance to eat and staff encouraged her to get up for meals. NA-C stated if R5 does not get out of bed, then her fluids should not be left in front of her since she needs assistance.

-At 9:16 a.m. registered nurse (RN)-B explained thickened liquids were left in R5's room on the bedside table so it would prompt staff to offer fluids, "hydrate in and hydrate out." RN-B indicated it was easier to have the thickened liquids on the bedside table. RN-B stated if a resident was coughing on an item for three times, the item should be taken away and the nurse should be notified but if a resident was just coughing to clear then we don't necessarily say that needs to be reported.

-At 11:02 a.m. director of nursing (DON) indicated if a resident needs assistance and they eat in their room then the tray should go to the nurse. The nurse would then make the determination at the time if they are able to eat alone.

The facility undated Care Plans policy indicated all residents would have a comprehensive care plan that included measurable objectives and timetables to meet a resident's medical, nursing , mental and psychosocial needs that were identified in the comprehensive assessment. The care plan would also describe services that were being furnished to attain and maintain the resident's highest practicable physical, mental

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F 312	Continued From page 25 and psychosocial well being. In addition the procedure section of the policy indicated the care plan would be reviewed and revised at least quarterly by the care plan team after each assessment and as needed by the charge nurse. In addition, the Nursing Assistant Resident Plan of Care which is an abbreviated care plan would be given to the nursing assistants to cover the resident's activities of daily living needs. These plans would be written by the licensed nurse and given to the NAs. The plans will be written interventions regarding the resident's activities of daily living on admission and updated weekly, and/or with significant changes. and/or with hospital returns. Updates and revision are to also be made in the electronic care plan of each resident. All Changes are to be dated. A facility policy related to aspiration precautions was requested and not received.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed complete a comprehensive fall risk and mobility assessment	F 323	R33 will have a fall assessment completed on 10/28/2016 and a mobility assessment completed by physical	11/15/16

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F 323	Continued From page 26 following the identification of a decline in mobility and failed to provide mechanical lift support as directed by the care plan in order to minimize fall risk and discomfort for 1 of 2 residents (R33) reviewed for accidents and who required mechanical lift support which was not provided. Findings include: R33 had a decline in mobility and the facilty failed to complete a reassessment. In addition, staff failed to utilize a mechanical transfer lift as directed by the care plan. R33's Face Sheet indicated R33's was diagnosed with generalized muscle weakness, difficulty in walking, generalized edema, diabetes, chronic pain, and osteoporosis. R33's Physician visit note dated 9/8/16, also indicated peripheral circulatory disorder. R33's quarterly Minimum Data Set (MDS) dated 6/29/16, indicated R33 had mild cognitive impairment, functional impairment of one upper and one lower extremities, required extensive assistance from two staff for transfers and toileting, and could not stabilize without human assistance for surface to surface transfers. The MDS also indicated R33 was occasionally incontinent of bowel and bladder and had one fall without injury since the last assessment. R33's Activity of Daily Living Care Area Assessment (CAA) dated 10/15/16, indicated R33's previous level of mobility was assist of one with transfers and toileting and R33's care plan had been revised to reflect current level of functioning/assistance.	F 323	therapy onto ensure the best mode of transferring the resident. All residents with a significant change over the last quarter will be assessed for proper transfers if needed a therapy evaluation will be ordered. DON/designee will audit resident transfers daily to ensure resident's plan of care are being followed. Staff will be educated on 11/14/2016 and audits will be brought to QC on 11/15/2016. Analysis of the observations/audits and facilities compliance will be presented to our Quality Assurance Team and approved by the Administrator. The Quality Assurance Team will implement needed changes and determine the need for on-going monitoring/auditing after analysis. The facility will be in compliance by 11/15/2016	

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F 323	Continued From page 27 R33's functional range of motion (ROM) care plan last revised on 10/3/16, indicated R33 had decreased ROM in the right shoulder, right knee and hip related to arthritis, obesity, and muscle weakness with an increased need for assistance for transferring. The plan also indicated R33 had an increase in discomfort with movement of extremities. The alteration in pain care plan also revised on 10/3/16, directed staff to provide R33 assistance with mobility as needed, to reduce pain and prevent falls. To use adaptive equipment as ordered such as a PAL lift (mechanical lift used to assist resident to come to a standing position for transfers) and a wheelchair. However, R33's care plan for toileting later revised on 10/4/16, directed staff to use the PAL lift with assist from two staff members but may use assist of one if R33 was trying to self-transfer. The care plan for falls was then revised on 10/5/16, which indicated R33 was at risk for falling related to history of falls and occasional bladder incontinence and instructed staff R33 was assist of two staff with PAL lift for transfers and toileting and if resident was starting to self transfer, assist of one may be used. The care plan did not identify the level of fall risk. R33's undated Nursing Assistant Sheet provided by the facility on 10/4/16, directed staff R33 required assist of two staff members with the use of the PAL lift for toileting and transfers, however, may use one staff assist if R33 was attempting to self transfer which was hand written on the form with no start/stop date indicated. The form listed gait belt, wheelchair, and PAL lift as the assistive devices required for R33. R33's last electronic Fall Risk and Functional Assessment completed on 6/24/16, indicated R33	F 323		

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had one fall in the last three months, was at risk for falls related to osteoarthritis, diabetes, joint pain, use of medications to control hypertension, vitamin deficiency, and constipation. The assessment indicated R33 was assist of one for transfers and toileting. A copy of this 6/24/16, was requested and not received. R33's medical record did not reveal an updated Fall Risk and Functional Assessment was performed to reflect R33's change in mobility which identified the amount of assistance required according to the interventions revised on 10/3/16, or 10/416.

R33's progress notes from present back to 9/3/16, were reviewed and did not reveal documentation of R33's self-transfer attempts.

R33's restorative progress note dated 9/3/16, indicated R33 had declined in walking/transfers due to knee's hurting so bad and has had therapy, but did not improve due to had to use arms so much to get to standing position that R33's shoulder would hurt so bad that she could not use arms to stand and then could not stand at all. Therapy felt R33 was in need of assist of one to PAL lift for transfers, depending on her upper strength ability.

R33's progress note dated 9/29/16, indicated R33 continued to be hard to transfer with gait belt and had trouble standing due to not being able to bend her knees or pick her feet up to pivot.

On 10/4/16, at 3:37 p.m. R33's bathroom call light was on, nursing assistant (NA)-G was observed to enter the bathroom. R33 was sitting calmly in her wheelchair in the bathroom in front of the toilet. R33 informed NA-G she needed to use the restroom. NA-G directed R33 to use the grab

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bars to stand up. R33 used her left arm to reach for the grab bar. Once R33 had a hold of the grab bar and started to attempt to pull up she made facial grimaces and reported pain in her left shoulder. NA-G advised R33 to take her time and attempt again. R33 made another attempt while NA-G stood on her right side with her arm laced under R33's right arm. R33 lifted off the chair slightly, and sat back down. Another attempt was made in this fashion and R33 came to a standing position. R33 was not steady once in a standing position and required NA-G's assistance to keep her balance. NA-G asked R33 which way she would like to turn. R33 stated she wanted to turn towards her (counterclockwise). NA-G provided verbal cues on hand placement while turning. R33 used the wheelchair arms for support, the chair arms were shaking under the weight. While turning, R33 was not balanced and her lower extremities appeared weak as if knees were going to give out. R33 required constant verbal cues to complete the transfer. When R33 sat on the toilet, she was not straight and sitting more towards the left side. No gait belt was used for the transfer.

-At 3:47 p.m. R33 was finished in the restroom. NA-G and NA-H entered the room with a PAL lift. The NA's proceeded to transfer R33 from the toilet back to her wheelchair. R33 did not report pain and did not display non-verbal signs of discomfort.

-At 3:50 p.m. R33 stated the PAL lift was very helpful because it helps relieve the pain in her shoulder.

-At 3:54 p.m. NA-G was asked why the lift had not been used to transfer R33 onto the toilet.

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NA-G stated when staff arrived this morning, they weren't using the lift and then she had seen NA-H bring the PAL lift into the room and guessed it was because sometimes in the morning R33 used the lift because she was harder and in the afternoon staff did not use it because R33 transferred better.

-At 3:57 p.m. when asked when staff used the lift to transfer her, R33 stated "sometimes they use it, but not all the time. I don't tell them when to use it they do it when they want to." R33 stated during the last few months it was more difficult to transfer because of her arthritis and she preferred using the lift.

On 10/5/16, at 8:06 a.m. NA-I stated R33 required the lift with assist of two staff members. At the same time, NA-F confirmed this and stated the use of the lift had just recently been implemented because R33 was struggling with transfers. NA-F stated some staff may not know this yet because it was just changed. NA-F stated staff started using the lift because R33 started having more issues with transfers and she tolerated it better and had not complained of pain when used.

-At 11:17 a.m. licensed practical nursing (LPN)-A was asked how R33 transferred. LPN-A responded by reading what was on the Nursing Assist Sheet for transfers and confirmed an unawareness as to when the handwritten information was added. LPN-A was not aware if the nursing assistants were trained to assess and determine the level of assistance required to complete safe transfers for R33.

On 10/6/2016, at 8:46 a.m. registered nurse

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(RN)-B stated R33 had shown a decline in mobility within the last month of September. RN-B stated sometimes R33 would attempt to self-transfer and when staff seen that occurring they could use assist of one with a gait belt to complete the transfer. RN-B stated R33 required a lift because she was at risk for falling, but if she was attempting to self-transfer she could be assist of one to prevent falling, however, RN-B stated there was not a recent mobility assessment to determine the level of care required. RN-B confirmed R33 worked with therapy from 2/16/16, through 4/6/16, during which it seemed the more therapy worked with her for transfer ability, the more her arm hurt related to the amount of use. Upon discharge from therapy, the physical therapist recommended moderate contact guard assist, with staff participation of 76-98%. RN-B indicated R33's mobility was reviewed at the staff patient handling meeting at the end of September. RN-B indicated R33 was going to be referred to therapy again for strengthening related to her decline in transfer ability. RN-B reported the meetings were held monthly, part of monthly staff meeting, and the purpose of the meeting was to prevent injuries of resident's and staff. RN-B explained she was the one who updated the care plan and if there were inconsistencies in the care plan, the newest date of the intervention should be used. RN-B stated she expected staff to follow the care plan, and if staff noticed mobility changes they were to report this to the nurse which in turn, the nurse would then assess the resident's mobility and implement appropriate interventions and should also update the care plan.

The undated facility Care Plans policy indicated all residents would have a comprehensive care

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F 323	Continued From page 32 plan that would include measurable objectives and timetables to meet a residents medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment. The plan would describe the services that were to be furnished in order to attain and maintain the resident's highest practicable physical, mental and psychosocial well-being. The undated Facility Transfer policy indicated the nursing staff would provide a safe transfer for the dependent resident.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		11/15/16

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F 329	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately identify a clinical rational/ justification for polypharmacy of antidepressant medications for 1 of 5 residents (R1) in the sample who received four antidepressant medications on a daily basis without clinical justification for the combined use. Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/15/16, indicated R1 was diagnosed with major depressive disorder, diabetes, and hypertension. the MDS also indicated R1 had intact cognition and had not displayed mood or behavioral concerns during the assessment period but had received antidepressant medications daily. R1's annual MDS dated 1/15/16, also identified R1 as cognitively intact without mood or behavioral symptoms and R1 had received daily antidepressant medications. R1's Psychotropic Medication Care Area Assessment dated 1/15/16, indicated R1 had received antidepressant medications for depression and insomnia. R1's care plan dated 8/26/16, indicated R1 received antidepressant medication for the	F 329	R1 had a provider review antidepressants on 10/10/2016 and Trazadone was reduced. Provider will continue to work on GDR and if not successful , will ensure that there is documentation to explain the clinical justification. All residents with multiple antidepressants will be reviewed by the provider for possible GDR. Residents on multiple antidepressants will be reviewed every 90 days with periodic visits. DON/designee will audit that all residents have been reviewed by MD and report results to QC on 11/15/2016. Staff will be educated on 11/15/2016. Analysis of the observations/audits and facility compliance will be presented to our QA Team and approved by the administrator. The QA Team will implement needed changes and determine the need for on-going monitoring/auditing after analysis. The facility will be in compliance by 11/15/2016.	

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treatment of depression and insomnia. The plan directed the staff to administer the medications in accordance with the physicians orders and to monitor for side effects of the medication.

R1's current physicians order report dated 9/6/16-10/6/16, indicated R1 received the following:

-lexapro (an antidepressant medication) 20 milligrams (mg) once a day since 1/24/14, for major depression.
-Wellbutrin XL (an antidepressant medication) 150 mg once a day since 3/23/15, for major depression.
-Trazodone (an antidepressant medication) 150 mg once a day at bedtime since 10/8/15, for major depression.
-Doxepin (an antidepressant medication) 75 mg once a day at bedtimes since 10/11/15, for major depression.

During the survey conducted on 10/3/16, from 4:00 p.m. to 8:00 p.m., on 10/4/16, from 10:00 a.m. to 6:30 p.m., on 10/5/16, from 7:00 a.m. to 3:30 p.m. and on 10/6/16, from 8:00 a.m. to 1:30 p.m. R1 was observed to ambulate freely in the facility. She interacted appropriately with her peers and staff members. She was not observed to display any type of foul mood, crying, or isolation behaviors.

The consultant pharmacist notes revealed the following information:

- 7/6/16, the pharmacist requested the clinical

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F 329	Continued From page 35 rational to continue Trazodone 150 mg at bedtime to be documented or if appropriate consider reducing the medication. - 8/8/16, Trazodone to be addressed at time of next routine prescriber visits. - 9/13/16, receives Trazodone 150 mg at bedtime to promote rest. R1 was noted to sleep well at night. The pharmacist requested a trial dose reduction or if a reduction was not warranted to document the need for the current dose in a progress note. Review of R1's physician Nursing Home notes dated 2/15/16, indicated R1 had a diagnosis of major depression. The note indicated the staff had reported "more defiant behavior from patient" R1 denied feelings of helplessness or helplessness, however, she was incontinent urine. The physician indicated "a reduction in the dose of her antidepressant medication is not deemed appropriate." However, the note did not justify why R1 required four different antidepressant medications. R1's physician Nursing Home Note dated 4/14/16, did not address the use of the antidepressants. In addition, R1's 6/9/16, and 8/11/16, physician Nursing Home Notes also lacked review of the use of the antidepressants. On 10/5/16, at 9:40 a.m. nursing assistant (NA)-A stated R1 did not display any type of behaviors.	F 329		

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F 329	Continued From page 36	F 329		

On 10/6/16, at 9:33 a.m. registered nurse (RN)-A stated R1 did not display behaviors and was not currently being followed by psych services. She stated R1 occasionally would direct other residents while in pubic places and was incontinent of urine at times. RN-A stated R1 had started utilizing a C-Pap (continuous positive airway pressure) machine in March 2016, and was sleeping much better. RN-A reviewed R1's clinical record and verified the consultant pharmacist had requested the continued use of Trazodone to be addressed during the 7/6/16, and 8/8/16, consultant pharmacy reviews. However, the concern had not been addressed by the physician during the 8/11/16, physician visit. RN-A verified the record lacked justification for the continued use of four different antidepressant medications.

On 10/6/16, at 9:50 a.m. R1 stated he could not recall any episode of depression. She denied episodes of feeling sad, having bad moods and crying while at the facility.

On 10/6/16, at 10:55 a.m. the licensed social worker stated R1 had been stable for the past several months. She stated R1 had history of attention seeking behaviors and anger towards others, but could not recall the last time she had displayed behaviors towards others.

On 10/6/16, at 11:40 a.m. the director of nursing (DON) reviewed R1's clinical record and verified it lacked justification for the continued use of four antidepressant medications. She also confirmed the pharmacists recommendations had not been addressed.

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F 329	Continued From page 37 A policy related to polypharmacy was requested and none was provided.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the	F 334		11/15/16

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F 334	Continued From page 38 immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a resident received the appropriate pneumococcal vaccinations as recommended by the Centers for Disease Control for 1 of 5 residents (R31) reviewed who had not received the appropriate pneumococcal vaccinations.	F 334	R 31 will be offered PCV13. All residents records will be reviewed to ensure they have been offere4d PCV13 and offered accordingly. Upon admission, residents will be offered PCV13. All staff will be educated on 11/15/2016. DON/designee will audit monthly that all residents are up	

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F 334	Continued From page 39 Findings include: The Centers for Disease Control (CDC) recommendations indicated, "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 [pneumococcal polysaccharide vaccine 23] should receive a dose of PCV13. The dose of PCV13 should be administered at least one year after the most recent PPSV23 dose." R31 was admitted to the facility on 7/18/16. The Resident Face Sheet/immunization record indicated R31 had received a pneumococcal PPSV23 on 10/7/14. At the time of the immunization R31 was 85 years old. The clinical record lacked indication R31 had received the pneumococcal vaccination PCV13. On 10/6/16, at 8:30 a.m. registered nurse (RN)-A stated she was aware of the updated guidance provided by the CDC in 2015. She confirmed R31's record did not include documentation related to the PCV13 immunization. RN-A stated she would have to investigate R31's immunization record for further. On 10/6/16, at 11:30 a.m. the director of nurses stated the facilty was working with the local clinic to attempt to obtain a clear immunization record for each resident upon admission to the facilty.	F 334	to date or have been offered the PCV13 and report results to QC on 11/105/2016. Analysis of the observations/audits and facilities compliance will be presented to our QA Team and approved by the Administrator. The QA Team will implement needed changes and determine the need for on-going monitoring/auditing after analysis. The facility will be in compliance by 11/15/2016.	

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F 334	Continued From page 40 The undated Adminsitration of Prevnar 13, Pneumovax policy directed the staff to provide education and administration of the Prevnar 13 and Pneumovax 23 vaccine to the residents of the facility according the the CDC recommendations.	F 334		
F 373 SS=D	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care.	F 373		11/15/16

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F 373	Continued From page 41 NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 5 residents in the sample (R13) with identified swallowing difficulties received safe and appropriate assistance with eating and was not fed by paid feeding assistants.	F 373	R 13 has been reassessed and deemed complicated and will not be fed by a paid feeding assistant. All residents on puree diet or thickened liquids will be reassessed and not fed by a paid feeding assistant. It will be signified on a diet/texture sheet by highlighting the complicated residents name in red. This	

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F 373	Continued From page 42 Findings include: R13's quarterly Minimum Data Set (MDS) dated 8/12/16, indicated R13 was diagnosed with dementia, had severe cognitive impairment, required a mechanically altered diet and required total assistance of one staff for eating. R13's Nutritional Care Area Assessment (CAA) dated 11/13/15, indicated R13 was at moderate nutritional risk due to an inability to communicate hunger and thirst needs. R13 received a mechanically altered diet due to a history of picketing food with non chewing or swallowing difficulties noted. The assessment indicated R13 required adaptive cups (nosey cups) for liquids and she was dependent upon the staff for assistance with eating. R13's care plan dated 8/26/16, directed staff to provide and serve a pureed diet as ordered and to provide assist of one with eating. It also indicated R13 required adaptive cups ("nosey cups") for liquids. The plan indicated R13 occasionally pocked food in her mouth and would not swallow. The plan indicated some meals went well without problems and the next meals R13 would not remember or understand how to swallow. The Nursing Assessment of Resident Appropriateness to be fed by a Feeding Assistant dated 8/12/16, indicated R13 had not been assisted by a speech therapist, she did not have a swallowing protocol, she did not have a history	F 373	document is for staff use only, it is discreet but accessible by all staff. This will ensure that complicated residents are fed by appropriate staff. Stop signs will be removed from all resident's place cards. Facility policy will be updated to state that all paid feeding assistants will have access to a licensed nurse by using the dining room call light. Staff will be educated on 11/14/2016. DON/designee will audit daily that paid feeding assistants aren't assisting complicated residents and report to QC on 11/15/2016. Analysis of the observations/audits and facilities compliance will be presented to our Quality Assurance Team and approved by the Administrator. The Quality Assurance Team will implement needed changes and determine the need for on-going monitoring/auditing after analysis. The facility will be in compliance by 11/15/2016.	

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of aspiration pneumonia, the texture of R13's therapeutic diet was controlling any swallowing issues and R13 was safe to be fed by a paid feeding assistant.

R13's Nutritional Assessment dated 8/10/16, identified R13 at moderate risk of nutritional risk due to pureed diet and history of pocketing food without chewing or swallowing difficulties noted or observed.

The current undated diet order directed the staff to provide R13 with a pureed diet and thin liquids via a nosey cup.

The Speech Therapy Plan of Care dated 3/11/16, indicated R13 had been assessed by speech therapy due to a history of pocketing food while eating. R13 was discharged from speech therapy on 4/4/16, on a diet of puree solids and thin liquids. R13 demonstrated limited ability to follow instructions during the evaluations. No special feeding instructions were given at that time, but she was to continue on a pureed diet.

On 10/3/16, at 4:50 p.m. activity aide (AA)-A was observed to assist R13 with a pureed diet. R13 ate the meal via a spoon and drank her liquids which were served to her via an adaptive "nosey" cup. R13 was not observed to display difficulties with the meal. She was observed to accept the food presented to her on the spoon and drank the liquids without difficulty.

On 10/3/16, at 5:26 p.m. AA-A stated she had been through the paid feeding assistant course. She stated the only resident she was not allowed to feed was R22 as she had special instructions

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for eating. She confirmed R13 was on a pureed diet and utilized adaptive equipment during the meal.

On 10/4/16, at 12:00 p.m. R13 was observed to receive assistance with the noon meal from NA-A. R13 was not observed to display eating or chewing difficulties during the meal.

On 10/4/16, at 5:00 p.m. R13 was observed to receive assistance with the evening meal from NA-D. R13 was not observed to display eating or chewing difficulties during the meal.

On 10/5/16, at 8:10 a.m. housekeeper (HSKP)-A stated she worked as a paid feeding assistant during the breakfast meals. She stated she was able to assist any of the residents with meals except R22 as she had been identified as complicated. HSKP-A stated she usually fed R13 for meals, but she would be receiving her breakfast later than usually because it was her bath day.

Review of R1's Resident Progress notes revealed the following:

- 7/24/16, at 10:50 a.m. the registered nurse (RN) fed R13 her morning medication while she at breakfast. R14 held a bite of medications and a sip of juice in her mouth for 15-20 minutes while swishing it in her mouth. R13 did swallow the medications but refused to take the remaining medications or the breakfast meal.

-9/2/16, at 10:29 a.m. R13 refused to eat breakfast.

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- 9/6/16, at 8:52 p.m. R13 had pocked her bedtime medications and held them in her mouth and refused to swallow. The nursing staff had to manually remove the medication from her mouth

-9/8/16, at 8:44 a.m. R13 was noted to have problems swallowing her medications. The pharmacy was to be contacted to change her medications to liquid form if possible.

- 9/18/16, at 6:01 p.m. R13 had been very lethargic and very difficulty to keep awake during the meals.

On 10/5/16, at 12:40 p.m. RN-B stated while passing medications, she monitored the dining room to ensure the residents were being fed appropriately. She stated the staff members had a call light on either assist table to call for assistance whenever needed. She stated she could not recall any concerns with R13 during meals.

On 10/5/16, at 1:01 p.m. RN-A stated the paid feeding assistants had been utilized by the facility for the past year. She stated the feeding assistants were able to assist with feeding the dependent residents as long as they were not assessed as being complicated. RN-A stated at this time the facilty only had one resident who could not be assisted by the paid feeding assistants and that resident was R22. She stated R13's abilities to swallow may change from day to day. She confirmed R13 had a history of pocketing food but she did not choke on the food and she did not have a history of aspiration pneumonia. She confirmed R13 required a pureed diet and adaptive equipment but did not

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F 373	Continued From page 46 feel that these factors deemed her as complicated, therefore, she could be fed by the paid feeding assistants. On 10/5/16, at 1:40 p.m. the director of nurse (DON) stated R13's ability to be fed by the paid feeding assistants had been evaluated and assessed by the nursing staff. She confirmed R13's assessment dated 8/12/16, indicated she was able to fed by the paid feeding assistant, however, she had not been comprehensively reassessed after displaying difficulties with swallowing in September 2016. She confirmed R13 required a pureed diet, adaptive feeding equipment and displayed pocketing behaviors while being fed. She confirmed R13's swallowing abilities changed due to dementia process and was in need of reassessment. The undated Paid Feeding Assistant policy directed the facility to utilize paid feeding assistants to assist the nursing staff with meeting the nutritional needs of the resident. The policy indicated the paid feeding assist were not allowed to assist residents with a swallowing protocol/program written by the speech therapist, any resident who has been treated for aspiration pneumonia in the past 6 months or resident current being evaluated by speech therapy. Additionally, they were not to be involved with intravenous hydration or tube feedings or any other complicated feeding issues as designated by the supervising nurse. The list of current paid feeding assistants dated 9/30/16, identified 9 paid feeding assistants	F 373		

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F 373	Continued From page 47 utilized at the facility. The list also identified 9 residents (including R13) who required assistance with feeding. R22 was the only resident on the list identified as not being able to be assisted by the paid feeding assistants as she was "complicated." On 10/6/16, at 11:34 p.m. the DON stated she had reviewed the facility paid feeding assistant policy and criteria. She verified R13's eating abilities were complicated and R13 should not be fed by a paid feeding assistant.	F 373		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the recommendations provided by the licensed pharmacist were appropriately reported and acted upon by the director of nurses for 1 of 5 residents (R1) in the sample who had written pharmacist recommendations related to the request for the clinical justification or gradual dose reductions for	F 428	R1 had MD review pharmacy recommendation on 10/10/2016. MD will review all pharmacy recommendations by their next scheduled periodic or sooner if needed. A new PharmD recommendations folder has been created so the provider can review them at the time of the visit and to decrease risk	11/15/16

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F 428	Continued From page 48 the use of antidepressants, which were not acted on. Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/15/16, indicated R1 was diagnosed with major depressive disorder, diabetes, and hypertension. the MDS also indicated R1 had intact cognition and had not displayed mood or behavioral concerns during the assessment period but had received antidepressant medications daily. R1's annual MDS dated 1/15/16, also identified R1 as cognitively intact without mood or behavioral symptoms and R1 had received daily antidepressant medications. R1's Psychotropic Medication Care Area Assessment dated 1/15/16, indicated R1 had received antidepressant medications for depression and insomnia. R1's care plan dated 8/26/16, indicated R1 received antidepressant medication for the treatment of depression and insomnia. The plan directed the staff to administer the medications in accordance with the physicians orders and to monitor for side effects of the medication. R1's current physicians order report dated 9/6/16-10/6/16, indicated R1 received the following: -lexapro (an antidepressant medication) 20	F 428	of concern not being followed up on. All nursing staff will be educated on 11/14/2016. DON/designee will perform monthly audits to ensure PharmD recommendations are being followed up on and brought to QC on 11/15/2016. Analysis of the observations/audits and facilities compliance will be presented to our Quality Assurance Team and approved by the Administrator. The Quality Assurance Team will implement needed changes and determine the need for on-going monitoring/auditing after analysis. The facility will be in compliance by 11/15/2016.	

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	245502	A. BUILDING _____ B. WING _____	10/06/2016

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 428	Continued From page 49 milligrams (mg) once a day since 1/24/14, for major depression. -Wellbutrin XL (an antidepressant medication) 150 mg once a day since 3/23/15, for major depression. -Trazodone (an antidepressant medication) 150 mg once a day at bedtime since 10/8/15, for major depression. -Doxepin (an antidepressant medication) 75 mg once a day at bedtimes since 10/11/15, for major depression. During the survey conducted on 10/3/16, from 4:00 p.m. to 8:00 p.m., on 10/4/16, from 10:00 a.m. to 6:30 p.m., on 10/5/16, from 7:00 a.m. to 3:30 p.m. and on 10/6/16, from 8:00 a.m. to 1:30 p.m. R1 was observed to ambulate freely in the facility. She interacted appropriately with her peers and staff members. She was not observed to display any type of foul mood, crying, or isolation behaviors. The consultant pharmacist notes revealed the following information: - 7/6/16, the pharmacist requested the clinical rational to continue Trazodone 150 mg at bedtime to be documented or if appropriate consider reducing the medication. - 8/8/16, Trazodone to be addressed at time of next routine prescriber visits. - 9/13/16, receives Trazodone 150 mg at bedtime to promote rest. R1 was noted to sleep well at night. The pharmacist requested a trial dose reduction or if a reduction was not warranted to	F 428		

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F 428	Continued From page 50	F 428		

document the need for the current dose in a progress note.

Review of R1's physician Nursing Home notes dated 2/15/16, indicated R1 had a diagnosis of major depression. The note indicated the staff had reported "more defiant behavior from patient" R1 denied feelings of helplessness or helplessness, however, she was incontinent urine. The physician indicated "a reduction in the dose of her antidepressant medication is not deemed appropriate." However, the note did not justify why R1 required four different antidepressant medications.

R1's physician Nursing Home Note dated 4/14/16, did not address the use of the antidepressants. In addition, R1's 6/9/16, and 8/11/16, physician Nursing Home Notes also lacked review of the use of the antidepressants.

On 10/5/16, at 9:40 a.m. nursing assistant (NA)-A stated R1 did not display any type of behaviors.

On 10/6/16, at 9:33 a.m. registered nurse (RN)-A stated R1 did not display behaviors and was not currently being followed by psych services. She stated R1 occasionally would direct other residents while in pubic places and was incontinent of urine at times. RN-A stated R1 had started utilizing a C-Pap (continuous positive airway pressure) machine in March 2016, and was sleeping much better. RN-A reviewed R1's clinical record and verified the consultant pharmacist had requested the continued use of

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F 428	Continued From page 51	F 428		

Trazodone to be addressed during the 7/6/16, and 8/8/16, consultant pharmacy reviews. However, the concern had not been addressed by the physician during the 8/11/16, physician visit. RN-A verified the record lacked justification for the continued use of four different antidepressant medications and the consultant pharmacist recommendation had not been acted upon.

On 10/6/16, at 9:50 a.m. R1 stated he could not recall any episode of depression. She denied episodes of feeling sad, having bad moods and crying while at the facility.

On 10/6/16, at 10:55 a.m. the licensed social worker stated R1 had been stable for the past several months. She stated R1 had history of attention seeking behaviors and anger towards others, but could not recall the last time she had displayed behaviors towards others.

On 10/6/16, at 10:07 a.m. the consultant pharmacist stated a request for clinical justification for a continued use of medication or a suggestion related to a gradual dose reduction should be addressed during a routine physician visit. She stated it was not appropriate for a suggestion from the pharmacist to be written three months in a row without a response from the physician.

On 10/6/16, at 11:40 a.m. the director of nursing (DON) reviewed R1's clinical record and verified it lacked justification for the continued use of four antidepressant medications. She confirmed the consultant pharmacist requests had not been addressed as directed.

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F 428	Continued From page 52 The undated Pharmacist Medication Regimen Review policy directed the facility to ensure resident medication regimens were reviewed by a pharmacist monthly. The results of the pharmacist review were to be sent to the facilty within 24 hours and maintained in the medical record. The policy did not direct the staff how to ensure the recommendations were to be communicated to the physician.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility 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. (3) The facility must require staff to wash their	F 441		11/15/16

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F 441	Continued From page 53 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an ongoing surveillance program to analyze patterns and trends of resident infections not treated with an antibiotic. This had the potential to affect all 44 residents residing in the facility. In addition, the facility failed to complete hand hygiene during personal cares for 1 of 7 residents (R35) observed to receive personal cares. Findings include: On 10/6/16, at 8:30 a.m. the facility Infection Summary Reports/infection control logs were reviewed with registered nurse (RN)-A who served as the infection control preventionist. RN-A stated the logs were up to date. The logs consisted of a computer generated report printed off of the electronic record system entitled: Infection Summary Report. The last report had been printed on 9/21/16, which contained the information for 8/1/16-8/31/16. The report logs did not include any type of information for 9/2016, or 10/2016.	F 441	Facility has developed a daily infection control log that will encompass all infections and facility mapping. Comprehensive analysis of infection surveillance logs and reports will be completed monthly during QC. IDT team will review all residents displaying symptomology of infectious process and or treatment of infection daily to ensure appropriate interventions, (isolation, any precautions) are in place to prevent the spread of infection to others. All residents will receive appropriate hand hygiene during personal cares. All staff will be educated on 11/14/2016. DON/designee will audit infection control log weekly to ensure its properly filled out. DON/designee will audit employee hand hygiene daily and bring results to QC on 11/15/2016. Comprehensive analysis of infection surveillance logs and reports will be completed monthly during QC. IDT will review all residents displaying symptomology of infectious process and or treatment of infections daily to ensure appropriate interventions(isolation,any	

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F 441	Continued From page 54 The Infection Summary Report identified the source of infection such as blood, ear, eye, gastrointestinal, respiratory, skin urinary tract and other. It identified if the infection was acquired in house or if the resident was admitted with the infection. The total number or residents identified. If the resident required isolation precautions and if it was a repeat infection in the past 90 days. The logs did not indicate which resident was involved, where the infection was for that resident, the date of symptom onset, how the infection was treated, the origin of the infection/bacterial, fungal or viral. It did not include the organism involved in the infection or when the infection resolved. Attached to the month Infection Summary Report included the progress notes from the clinical records of the residents who were identified to have the infection. The January 2016, printed on 2/17/16, indicated the facilty had 12 identified residents with an upper respiratory infection. Review of the Progress notes attached to the report indicated several residents had been treated with Zithromax (antibiotic) and Tamiflu (medication for the treatment of influenza). On 10/6/16, at 8:40 a.m. RN-A stated the Infection Summary Reports were generated by the electronic computer system and were printed monthly. She stated the facilty staff members discussed the infections daily at the morning interdisciplinary team meetings, and they had notes from the IDT meetings, but they were not	F 441	precautions) are in place to prevent the spread of infections to others. DON/designee will ensure that daily log is filled out and results are brought to QC on 11/15/2016. Analysis of the observations/audits and facilities compliance will be presented to our QA Team and approved by the Administrator. The QA Team will implement needed changes and determine the need for on-going monitoring/audits after analysis. The facility will be in compliance by 11/15/2016.	

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F 441	Continued From page 55 part of the infection control monitoring system. She stated the only residents who were monitored for infections were those who had been treated with an antibiotic. She stated if a resident did not receive treatment with an antibiotic, the facility did not have a system to monitor the infection, illness or symptomology. Upon review of the January 2016, infection report RN-A verified the facility had an outbreak of influenza- A at that time. She stated all of the residents in the facility received Tamiflu as a preventative measure, visitors were encouraged to limit visits and the director of nurses (DON) had reported the outbreak to the State Agency. She verified the Infection Summary Reports did not include the preventative interventions put into place during the influenza outbreak. When asked how many residents had received Tamiflu, RN-A stated she would have to go back and look at each individual record of the residents who were residing in the facilty at that time. She verified she did not complete any type of summary or analysis of the infections on a monthly basis. She stated she reported the information from the reports to the quality assurance committee but confirmed the report did not include a comprehensive analysis of the infections and a system to monitor the infections on a daily, ongoing basis had not been established. The Nosocomial Infection Surveillance policy dated 2000, directed the facility to identify an infection control nurse to monitor, investigate and set forth a control plan to prevent unnecessary nosocomial infections. The policy directed the infection control nurse to evaluate each resident	F 441		

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F 441	Continued From page 56 for infections on a monthly basis, and to provide monthly reports to the Quality Council. The policy did not direct the staff how to complete timely reports which would allow the staff to identify concerns before outbreaks and it did not direct the staff to monitor infections which were not related with antibiotic use. R35's personal cares were observed and completed without proper handwashing. On 10/5/16, at 8:50 a.m. R35's personal cares were observed. Nursing assistant (NA)-F entered R35's room and greeted him. NA-F washed and dried R35's face. NA-F retrieved R35's clothes from the dresser and removed his pajama pants. Licensed practical nurse (LPN)-A entered the room and stated she was there to apply ace wraps to R35's legs. NA-I entered the room to assist NA-F with cares. NA-F and NA-I donned gloves and NA-F proceeded to open R35's incontinent brief and wash his groin. LPN-A applied lotion to R35's legs. NA-F and NA-I rolled R35 to his left side and removed the incontinent brief which was slightly wet. NA-F washed R35's perineal area, applied barrier cream to his bottom and applied a clean incontinent brief. NA-I discarded her gloves and exited the room. With the same gloved hands, NA-F assisted LPN-A to apply wraps to R35's lower legs. NA-F placed R35's pants on his lower legs. NA-F and LPN-A assisted R35 to turn and pulled up pants and placed a mechanical lift sling under R35 and transferred R35 into the wheelchair. Once in the wheelchair, NA-F removed R35's undershirt, applied deodorant and assisted him to don a clean undershirt. NA-F shaved R35's face, brushed his hair and put slipper socks on his feet. At this time, NA-F	F 441		

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F 441	Continued From page 57	F 441		

removed and discarded her gloves and without performing hand hygiene and donned clean gloves. NA-F placed her gloved fingers inside R35's mouth to assist him to remove his upper denture plate and proceeded to swab R35's mouth with a moist toothette and brushed his top denture plate. NA-F assisted R35 to place the plate back in his mouth. R35 wanted the plate out and NA-F assisted him to remove it and placed it in a cup. NA-F wheeled R35 from the room and returned to bag the garbage and tidy the room.

On 10/5/16, at 9:44 a.m. NA-F confirmed she had not washed her hands before putting on clean gloves and she should have done so.

On 10/6/16, at 11:29 a.m. registered nurse (RN)-B verfied she would expect handwashing to be done after removing gloves and before putting on new gloves during personal cares.

The undated Handwashing policy directed hand were to be washed after contact with a source of body fluids, mucous membranes and after the removal of gloves.

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	245502	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**10/06/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY Building 01 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Benedictine Care Community 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY 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:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/27/2016

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@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 is a 1-story building without a basement. The building was constructed in 2000 and was determined to be of Type II(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. In 2013 a chapel/ assisted living building was constructed to the north of the care center, is 1-story, no basement and Type V (111) construction. The buildings are fully sprinkler protected with quick response sprinklers in accordance with NFPA 13 Standard for the Installation of Automatic Sprinklers 1999 edition. The facility 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 and installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition.	K 000		

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K 000	Continued From page 2 Other hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The sleeping rooms have single station smoke detectors that annunciate outside the room and at the nurse's station in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm system has automatic fire department notification. The facility has a capacity of 49 beds and had a census of 44 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 44 residents and an undetermined amount of staff and visitors. Findings include:	K 062	In accordance with NFPA 101 Life safety code (00), section 19.7.6 and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99) and NFPA 25 Standard for Inspection the facility will be in compliance on 11/15/2016. Nardina was called on 10/08/2016 and an appointment set up for date of calibration and or replacement of the sprinkler riser gauges and will be documented. The facility will create a process whereas they will followed up with Nardina to do the calibration within the 5 year timeframe. When calibration has been completed an audit of the sprinkler system documentation/ compliance done	11/15/16

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

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K 062	Continued From page 3 On the facility tour between 9:00 am to 12:00 pm on 10/6/2016, observations, record review and staff interview revealed there was no date of calibration or replacement of the the sprinkler riser gauges within the last 5 years. This deficient practice was confirmed by the Facility Administrator and Maintenance Supervisor.	K 062	by environmental services director/Administrator ,will be given to QA committee and approved by the Administrator.The QA team will implement needed changes and determine if their is a need for on-going monitoring/auditing. This would affect all residents, visitors and staff. The facility will be in compliance by 11/15/2016.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all 44 residents, staff, and visitors. Findings include: On the facility tour between 9:00 am to 12:00 pm on 10/6/2016, record review and staff interview revealed the generator records did not have the cool down cycle logged. This deficient condition was confirmed by the Facility Administrator and the Maintenance Supervisor.	K 144	According to the NFPA 99 and NFPA 110, the facility has to test the emergency generators to insure the generators are inspected weekly and exercised under load, was done and documented in an audit on 10/25/2016. Audits will be done by maintenance department to ensure compliance with the testing of generators. These audits will be presented to QA Team on 11/15/2016 and quarterly after to ensure compliance. Analysis of the audits and facility compliance will be presented to our Team and approved by the Administrator. The QA Team will implement needed changes, if needed, to ensure facility compliance is met. This would affect all residents within our facility. Facility will be in compliance by 11/15/2016.	11/15/16
K 211	NFPA 101 LIFE SAFETY CODE STANDARD	K 211		11/15/16

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 _____	**10/06/2016**

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K 211 SS=F	Continued From page 4 Where Alcohol Based Hand Rub (ABHR) dispensers are installed: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers shall have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623 This STANDARD is not met as evidenced by: Based on observation and staff interview it has been observed that the facility has not installed the Alcohol Based Hand Rub (ABHR) dispensers according to NFPA 30 and the MN State Fire Code (07) section 3405.5 This deficient condition could allow the product to ignite and start a fire, adversely affecting all residents and an undetermined amount , staff and visitors. Findings include: On the facility tour between 9:00 am to 12:00 pm on 10/6/2016, observations, and staff interview revealed 2 ABHR's in the main dining area were directly above electrical outlets. This deficient condition was confirmed by the Facility Administrator and the Maintenance Supervisor.	K 211	Two Alcohol based hand Rub dispensers, in dining room, were removed on October 6, 2016. This was done to ensure the dispensers were not located above any ignition sources. Audits will be done on all dispensers to ensure facility compliance, by the environmental department/administrator and given to the QA committee and approved by the administrator. The QA committee will implement any needed changes and determine if there is a need for on-going monitors/audits. This deficiency affects all residents and staff and visitors within the facility. The facility will be in compliance by 11/15/2016.	

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 _____	**10/06/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY Building 02 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Benedictine Care Community 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY 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:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/27/2016

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 _____	**10/06/2016**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@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 is a 1-story building without a basement. The building was constructed in 2000 and was determined to be of Type II(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. In 2013 a chapel/ assisted living building was constructed to the north of the care center, is 1-story, no basement and Type V (111) construction. The buildings are fully sprinkler protected with quick response sprinklers in accordance with NFPA 13 Standard for the Installation of Automatic Sprinklers 1999 edition. The facility 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 and installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition.	K 000		

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	245502	A. BUILDING **02 - CHAPEL** B. WING _____	**10/06/2016**

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K 000	Continued From page 2 Other hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The sleeping rooms have single station smoke detectors that annunciate outside the room and at the nurse's station in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm system has automatic fire department notification. The facility has a capacity of 49 beds and had a census of 44 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 18.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 44 residents and an undetermined amount of staff and visitors. Findings include:	K 062	See building 1, K062. POC. This would affect all residents and visitors and staff. The facility will be in compliance by 11/15/2016.	11/15/16

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	245502	A. BUILDING **02 - CHAPEL** B. WING _____	**10/06/2016**

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K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all 44 residents, staff, and visitors. Findings include: On the facility tour between 9:00 am to 12:00 pm on 10/6/2016, record review and staff interview revealed the generator records did not have the cool down cycle logged. This deficient condition was confirmed by the Facility Administrator and the Maintenance Supervisor.	K 144	See building 1 POC of K144. This would affect all residents, visitors, and staff. The facility will be in compliance by 11/15/2016.	11/15/16