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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6DLY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00399

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245501**

2. STATE VENDOR OR MEDICAID NO. (L2) **849623400**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY**
(L4) **1907 KLEIN STREET**
(L5) **ST PETER, MN** (L6) **56082**

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) **10/01/2004**

6. DATE OF SURVEY **8/8/2016** (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) **12/31**

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

12.Total Facility Beds **79** (L18)

13.Total Certified Beds **79** (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
	79			
(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 :
Kathryn Serie, Unit Supervisor 9/27/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 9/27/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **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. **03001** (L31)

30. REMARKS
Posted 08/10/2016 Co.

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

CMS Certification Number (CCN): 245501

September 27, 2016

Ms. Linda Nelsen, Administrator
Benedictine Living Community
1907 Klein Street
St Peter, MN 56082

Dear Ms. Nelsen:

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 July 21, 2016 the above facility is certified for:

79 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 79 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 22, 2016

Ms. Linda Nelsen, Administrator
Benedictine Living Community
1907 Klein Street
St Peter, MN 56082

RE: Project Number S5501026

Dear Ms. Nelsen:

On July 12, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 29, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On August 8, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 29, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 21, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 29, 2016, effective July 21, 2016 and therefore remedies outlined in our letter to you dated July 12, 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 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
245501 Y1	A. Building B. Wing Y2	8/8/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	1907 KLEIN STREET ST PETER, MN 56082

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 F0309	Correction	ID Prefix F0312	Correction	ID Prefix F0314	Correction
Reg. # 483.25	Completed	Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(c)	Completed
LSC	07/21/2016	LSC	07/21/2016	LSC	07/21/2016
ID Prefix F0356	Correction	ID Prefix F0465	Correction	ID Prefix	Correction
Reg. # 483.30(e)	Completed	Reg. # 483.70(h)	Completed	Reg. #	Completed
LSC	07/21/2016	LSC	07/31/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		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
	KS/kfd	8/22/2016	03048	8/8/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/29/2016

☐ 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**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6DLY

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(L3) **BENEDICTINE LIVING COMMUNITY**
(L4) **1907 KLEIN STREET**
(L5) **ST PETER, MN** (L6) **56082**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **10/01/2004**

6. DATE OF SURVEY **06/29/2016** (L34)

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0 Unaccredited 1 TJC
2 AOA 3 Other

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

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Compliance Based On:
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And/Or Approved Waivers Of The Following Requirements:
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___ 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
	79			
(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 : 07/22/2016
Wendy Willson, HFE NE II (L19)

18. STATE SURVEY AGENCY APPROVAL Date: 08/05/2016
Kamala Fiske-Downing, Health Program Representative (L20)

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

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
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04-Other Reason for Withdrawal
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05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS
Posted 08/10/2016 Co.

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
July 12, 2016

Ms. Linda Nelsen, Administrator
Benedictine Living Community
1907 Klein Street
St Peter, MN 56082

RE: Project Number S5501026

Dear Ms. Nelsen:

On June 29, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the June 29, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5501013 that was found to be unsubstantiated.

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:

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

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 August 8, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 September 29, 2016 (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 December 29, 2016 (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 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	1907 KLEIN STREET ST PETER, MN 56082

(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. An investigation of complaint H#5501013 was completed and found not to be substantiated.	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure services were coordinated with the hospice provider for 1 of 1 resident (R143) reviewed for hospice. Findings include:	F 309	1. Measurements of resident #143 wound area was completed on 6/28/16. Weekly measurements were initiated on the residents care plan and reviewed with the Hospice RN-B on 6/28/16. The care plan includes the willingness of the resident to participate due to level of pain	7/21/16

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

Electronically Signed | 07/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 309	Continued From page 1 R143 was admitted on 4/29/16, with diagnoses per the care plan dated 5/19/16, including: Palliative care, malignant neoplasm of rectum, malignant neoplasm of renal pelvis, carcinoma of liver, gallbladder, bronchus and lung; severe protein calorie malnutrition, colostomy complication-fistula, shortness of breath requiring oxygen and nausea with vomiting. The admission Minimum Data Set (MDS) assessment dated 5/7/15, identified R143 with a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. The assessment further identified R143 as at risk for a pressure ulcer (PU). A Tissue Tolerance Assessment dated 4/30/16, identified the coccyx as pink and blanches, after lying on back;-no redness to other bony prominence's. R143 had no open areas related to pressure documented on the admission assessment. Review of the document titled Pressure Sore/ Stasis Ulcer dated 5/12/16, at 4:50 a.m. identified a Stage I pressure ulcer (PU)- persistent area of skin redness, without a break in the skin, that does not disappear when pressure is relieved. Surrounding tissue is indurated, macerated, erythema present. R143 was experiencing mild pain identified as uncomfortable and annoying. The document further identified contributing factors which included decreased food intake, weight loss and PU history. The care plan dated 5/19/16, also identified R143 at risk for PU due to friction, sheer, nutrition, activity, and chair fast; on hospice benefit and takes very little nutrition due to disease process. The hospice care plan titled IDT (interdisciplinary team) Care Plan dated	F 309	at the time. The resident would be reproached if an alternative time is necessary. 2. Wounds are identified by nurse involved with care delivery. Upon identification an event in the medical record is entered and wound protocol is initiated in the treatment record. 3. The Director of Nursing met with the Director of the Hospice involved on 7/18/16 to coordinate communication and protocol to address care plans for this agency. The Nurse Manager and Hospice Nurse will meet regularly to review the plan of care for consistency. Findings were reviewed and education provided to nursing staff at nursing meeting on 7/13/16. Review of deficiency and plan of correction was presented at facility Quality Council Meeting on 7/21/16. 4. Corrective action was comleted 7/21/16	

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F 309	Continued From page 2 4/29/16 to 7/27/16, indicated the patient [R143] will demonstrate compliance with wound care regimen and identified the following: (1.) Monitor skin for redness, warmth, and integrity with each skilled nurse visit; (2.) Assess wound location, drainage, surrounding skin, pain effectiveness of treatment, wound bed color and size; (3.) Wound care both sides of coccyx: apply Mepilex daily and PRN (as needed); and (4.) Wound care right ischium. Apply Mepilex every 3 days and PRN soiled or loose, (added on 5/20/16). Documentation in the record identified a fax dated 5/12/16, which included: "the resident has a new pressure sore to left of coccyx which measures 1.5 x 2 cm and it looks purplish/black. Skin red on bottom, skin mostly intact. There was a new order for a Mepilex dressing change every 3 days". The order from the nurse practitioner (NP) dated 5/16/16, indicated: coccyx wound orders- clean with wound wash. apply barrier cream and island dressing and or 4 x 4 Mepilex. Change daily and as needed. Review of R143's Treatment Administration History revealed the coccyx wound dressing was changed every third day and monitoring of the redness to the bottom was initialed every shift. Documentation in the record was lacking to indicate a nursing assessment had been conducted related to the condition and measurements of the wound by facility and/or the hospice nursing staff. Review of the nursing progress notes identified the following: -6/15/16-Resident complained of her buttock being sore from her mattress. Resident states, "I have to find the right groove to make it	F 309		

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F 309	Continued From page 3	F 309		

comfortable", call placed to hospice and they will bring a pressure reducing mattress for her tomorrow;
-6/22/16- did cleanse the wound with saline and apply new Mepilex border on coccyx wound which is a stage 2-3. Most of the wound bed is yellow/green in color. Wound does have some odor. A second Mepilex applied on right ischial area which is stage two; and
-6/29/16-Wound has very foul smell when dressing is removed and old dressing saturated with purulent drainage. Wound on coccyx measures 4.5 x 5 cm (centimeters) and is 0.3 cm at deepest point. Wound bed is 100% yellow slough. Black necrotic tissue noted at wound edge at 7 o'clock. Necrotic area measures 1 cm 0.3 cm. Second wound on left buttock below coccyx measures 2.8 x 2.5 cm. Wound bed is red and superficial. Skin surrounding wounds is red and intact.

When interviewed on 6/28/16, at 9:30 a.m. registered nurse (RN)-A stated that R143's Mepilex dressing is changed every 3 days in the evening and was last changed on 6/27/16. RN-A stated she had not recently viewed the wound and confirmed a wound assessment had not been completed since 5/11/16. RN-A verified this after a review of the electronic medical record.

When interviewed on 6/28/16, at 2:55 p.m. the director of nursing (DON) stated she had been in contact with the hospice provider. The DON stated the hospice nurse indicated she did not believe that they [hospice] needed to measure and monitor pressure ulcers. Interventions listed in the 4/29/16, hospice care plan related to the PU were reviewed with the DON and included the following: (1.) Monitor skin for redness, warmth,

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F 309	Continued From page 4 and integrity with each skilled nurse visit; and (2.) Assess wound location, drainage, surrounding skin, pain effectiveness of treatment, wound bed color and size. The DON replied, "that's interesting, she will want to talk with you when she arrives." [Referencing the hospice nurse]. When interviewed on 6/28/16, at 3:51 p.m. hospice nurse RN-B confirmed that review of the hospice record omitted assessment and PU documentation. There was one entry on 6/8/16 and 6/22/15 by hospice nurse. RN-B stated she would review with the hospice team the necessity for assessment, monitoring, and intervention of the pressure wounds at least weekly. A lack of coordination of care between the facility staff and hospice was evident. The policy titled Hospice Program reviewed 6/2016, included: (4.) If hospice becomes involved in the care of the resident: (d.) The hospice retains overall responsibility for directing and coordinating the plan of care related to the terminal illness and related conditions such as wound care.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 312	1. Chin hairs and soiled clothing were	7/21/16

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F 312	Continued From page 5 review the facility failed to provide personal assistance with shaving and dressing needs for 1 of 4 residents (R47) reviewed for activities of daily living. Findings included: During observations on 6/27/16 at 3:27 p.m., 6/28/16 at 8:38 a.m. and 6/29/16 at 7:58 a.m., R47 was observed to have long thin black/gray facial hairs on her chin and upper lip which measured approximately 1/4 to 1 inch in length. R47's diagnoses per the care plan dated 4/22/16, included: muscle weakness and blindness of both eyes. R47's quarterly Minimum Data Set (MDS) dated 4/7/16, included a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating moderate cognitive impairment. The assessment also indicated R47 required extensive physical assist from one staff member for personal hygiene and for dressing. R47's care plan dated 4/22/16 included a self-care deficit in areas of dressing, bathing, and grooming. The care plan revealed "Family will assist resident with shaving any facial hair, they do not feel they need to provide a electric razor and when they visit they will pluck any facial hair". When interviewed on 6/29/16, at 7:58 a.m. R47 stated she used to take care of the facial hair herself when still at home. R47 stated staff help her now and her choice would be to have the hair removed from her chin. R47 is observed to have the same shirt on her that she had on 6/28/16. It is soiled with dried on food debris which is	F 312	addressed for Resident #47 on 6/29/16. 2. Grooming procedures were reviewed with nursing staff members at nursing meeting on 7/13/16. 3. New procedure was initiated that all residents will be asked regularly whether or not they want facial hair removed regardless of family opinion. Nurse Managers will audit weekly. The deficiency and plan of correction was reviewed at the Quality Council meeting on 7/21/16. 4. Corrective action was completed 7/21/16.	

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F 312	Continued From page 6 dripped down the front of her blouse from neckline to stomach. When interviewed on 6/29/16, at 8:49 a.m. the nurse manager (NM)-B stated R47's daughter was at the facility for R47's birthday two days ago and "evidently did not take care of the facial hair." When informed R47 stated it would bother her to have facial hairs and would want them removed, NM-B confirmed there was not a plan/alternate method to provide the personal assistance with the hair removal when not completed by the family. When interviewed on 6/29/16, at 9:12 a.m. trained medication aide (TMA)-A stated staff encourage R47 to help participate with her cares. TMA-A stated staff need to assist R47 with completing simple tasks, such as combing hair and brushing teeth. TMA-A confirmed the presence of the long facial hairs and the soiled blouse. TMA-A stated staff are directed to leave the facial hair for R47's daughter to remove, and verified there was not an available razor supplied by the facility for resident use nor an alternate method. When interviewed on 6/29/16, at 12:45 p.m. the director of nursing (DON) confirmed a community razor was not provided by the facility due to infection control purposes. The DON stated family members are requested to provide razors and multiple attempts had been made for R47's family to bring in a razor.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		7/21/16

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F 314	Continued From page 7 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to provide ongoing monitoring, assessment and intervention to reduce the risk of further development or deterioration of a pressure ulcer for 1 of 1 (R143) resident reviewed with a PU. Findings include: R143 was admitted on 4/29/16, with diagnoses per the care plan dated 5/19/16, including: Palliative care, malignant neoplasm of rectum, malignant neoplasm of renal pelvis, carcinoma of liver, gallbladder, bronchus and lung; severe protein calorie malnutrition, colostomy complication-fistula and shortness of breath requiring oxygen. The admission Minimum Data Set (MDS) assessment dated 5/7/15, identified R143 with a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. The assessment further identified R143 as at risk for a pressure ulcer (PU). A Tissue Tolerance Assessment dated 4/30/16, identified the coccyx as pink and blanches, after lying on back;-no redness to other bony prominence's. R143 had	F 314	1. Measurements of resident #143 wound area was completed on 6/28/16. Weekly measurements were initiated on the resident's care plan on 6/28/16 and reviewed with the Hospice RN-B. Weekly measurements are based on the resident's willingness to participated as indicated by the level of pain. If the level of pain contraindicates the initiation of the plan of care the resident will be reproached for a more suitable time for treatment. 2. Residents at risk of pressure ulcers will be identified upon admission with skin risks. Nurse Manager will care plan accordingly and educate nursing staff members. 3. If pressure ulcer noted, an event will be entered into medical record by the nurse and wound protocol will be initiated in the treatment record. The Wound Nurse and Nurse Manager will be notified along with Nurse Practitioner and/or Clinical Wound Nurse to develop treatment plan. The Wound Nurse will round weekly and take	

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F 314	Continued From page 8 no open areas related to pressure documented on the admission assessment. Review of the document titled Pressure Sore/ Stasis Ulcer dated 5/12/16, at 4:50 a.m. identified a Stage I pressure ulcer (PU)- persistent area of skin redness, without a break in the skin, that does not disappear when pressure is relieved. Surrounding tissue is indurated, macerated, erythema present. R143 was experiencing mild pain identified as uncomfortable and annoying. The document further identified contributing factors which included decreased food intake, weight loss and PU history. The care plan dated 5/19/16, also identified R143 at risk for PU due to friction, sheer, nutrition, activity, and chair fast; on hospice benefit and takes very little nutrition due to disease process. The hospice care plan titled IDT (interdisciplinary team) Care Plan dated 4/29/16 to 7/27/16, indicated the patient [R143] will demonstrate compliance with wound care regimen and identified the following: (1.) Monitor skin for redness, warmth, and integrity with each skilled nurse visit; (2.) Assess wound location, drainage, surrounding skin, pain effectiveness of treatment, wound bed color and size; (3.) Wound care both sides of coccyx: apply Mepilex daily and PRN (as needed); and (4.) Wound care right ischium. Apply Mepilex every 3 days and PRN soiled or loose, (added on 5/20/16). Documentation in the record identified a fax dated 5/12/16, which included: "the resident has a new pressure sore to left of coccyx which measures 1.5 x 2 cm and it looks purplish/black. Skin red on bottom, skin mostly intact. There was a new order for a Mepilex dressing change every 3 days".	F 314	measurements of affected area. 4. The deficiency was reviewed and education provided to nursing staff members at the nursing meeting on 7/13/16 and at the Quality Council meeting on 7/21/16. Corrective action was completed on 7/21/16.	

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The order from the nurse practitioner (NP) dated 5/16/16, indicated: coccyx wound orders- clean with wound wash. apply barrier cream and island dressing and or 4 x 4 Mepilex. Change daily and as needed.

Review of R143's Treatment Administration History revealed the coccyx wound dressing was changed every third day and monitoring of the redness to the bottom was initialed every shift. Documentation in the record was lacking to indicate a nursing assessment had been conducted related to the condition and measurements of the wound by facility and/or the hospice nursing staff.

Review of the nursing progress notes identified the following:
-6/15/16-Resident complained of her buttock being sore from her mattress. Resident states, "I have to find the right groove to make it comfortable", call placed to hospice and they will bring a pressure reducing mattress for her tomorrow;
-6/22/16- did cleanse the wound with saline and apply new Mepilex border on coccyx wound which is a stage 2-3. Most of the wound bed is yellow/green in color. Wound does have some odor. A second Mepilex applied on right ischial area which is stage two; and
-6/29/16-Wound has very foul smell when dressing is removed and old dressing saturated with purulent drainage. Wound on coccyx measures 4.5 x 5 cm (centimeters) and is 0.3 cm at deepest point. Wound bed is 100% yellow slough. Black necrotic tissue noted at wound edge at 7 o'clock. Necrotic area measures 1 cm 0.3 cm. Second wound on left buttock below coccyx measures 2.8 x 2.5 cm. Wound bed is red

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and superficial. Skin surrounding wounds is red and intact.

When interviewed on 6/28/16, at 9:30 a.m. registered nurse (RN)-A stated that R143's Mepilex dressing is changed every 3 days in the evening and was last changed on 6/27/16. RN-A stated she had not recently viewed the wound and confirmed a wound assessment had not been completed since 5/11/16. RN-A verified this after a review of the electronic medical record.

When interviewed on 6/28/16, at 2:55 p.m. the director of nursing (DON) stated she had been in contact with the hospice provider. The DON stated the hospice nurse indicated she did not believe that they [hospice] needed to measure and monitor pressure ulcers. Interventions listed in the 4/29/16, hospice care plan related to the PU were reviewed with the DON and included the following: (1.) Monitor skin for redness, warmth, and integrity with each skilled nurse visit; and (2.) Assess wound location, drainage, surrounding skin, pain effectiveness of treatment, wound bed color and size. The DON replied, "that's interesting, she will want to talk with you when she arrives." [Referencing the hospice nurse].

When interviewed on 6/28/16, at 3:51 p.m. hospice nurse RN-B confirmed that review of the hospice record omitted assessment and PU documentation. There was one entry on 6/8/16 and 6/22/15 by hospice nurse. RN-B stated she would review with the hospice team the necessity for assessment, monitoring, and intervention of the pressure wounds at least weekly.

When interviewed on 6/29/16, at 2:30 p.m. the DON stated the facility had a wound nurse that

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F 314	Continued From page 11 rounded weekly. The DON confirmed the wound nurse had not reviewed R143's PU when discovered. The DON verified being notified of the new PU when discovered though the information had not been communicated to the wound nurse. Subsequently, the wound nurse became involved with the treatment/assessment of the PU on 6/29/16. The policy titled Hospice Program reviewed 6/2016, included: (4.) If hospice becomes involved in the care of the resident: (d.) The hospice retains overall responsibility for directing and coordinating the plan of care related to the terminal illness and related conditions such as wound care.	F 314		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to	F 356		7/21/16

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F 356	Continued From page 12 residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the current census and nursing hours on a daily basis. This had the potential to affect all 69 residents residing at the facility as well as family/visitors. Findings include: During initial tour of facility on 6/27/16, at 12:05 p.m. a Daily Staffing Form dated 6/24/16 was posted on a wall to the left of the entrance door. The Daily Staffing Form was dated 6/24/16 (3 days earlier), and indicated a census of 70. When interviewed on 6/27/16, at 1:45 p.m. the administrator stated the current census was only 69. On 6/27/16, at 1:48 p.m. the Daily Staffing Form was observed to have been updated to reflect current date and census of 69. When interviewed on 6/29/16, at 10:12 a.m. the health information coordinator (HIC) indicated she was in charge of updating the Daily Staffing Form	F 356	1. The daily staffing form was updated on 6/27/16. 2. The Director of Nursing reviewed the process of posting the schedule with the nursing management team, HIC, HUC and Administrator to assure a current schedule is posted. 3. On daily basis the Director of Nursing and HUC will have the updated form posted with current date, facility name, number of actual hours worked by category and resident census. This includes a nursing staff member assigned to update the daily staffing form. 4. Corrective action was completed on 7/21/16 after initiation of plan of correction, review and notification of deficiency with nursing staff members at nursing meeting on 7/13/16 and at the facility Quality Council meeting on 7/21/16.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 13 and stated she updates the posting daily Monday through Friday "first thing in the morning", and as needed. The HIC further indicated no one updates nor changes the posting on the weekends. She confirmed the Daily Staffing Form observed during the initial tour had not been updated from the weekend and reflected an inaccurate census. When interviewed on 6/29/16, at 10:12 a.m. the director of nursing (DON) confirmed the facility Daily Staffing Form is not updated or changed during the weekends stating "we just don't have the staff to do it".	F 356		
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 5 neighborhood pantries (Angel Wing) was maintained in a sanitary manner. This had the potential to affect 19 residents residing on the unit. Findings include: During observation on 6/27/16, at 6:34 p.m. the Angel Wing pantry oven was observed to have a light brown, sticky substance with food debris on the upper lip of the oven door, dried black debris	F 465	1. Immediate cleaning of unsanitary area in Angel pantry where deficient area was noted was completed on 6/28/16. All contact areas including stove top, oven door, bottom of the oven, exterior of cupboards, cupboard handles and floor surrounding dish machine and oven that was indicated was cleaned thoroughly and will continue to be maintained in a sanitary manner. All other contact surfaces were cleaned immediately as well and will continue to be cleaned and maintained in a sanitary manner.	7/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	06/29/2016

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F 465	Continued From page 14 in the bottom of the oven and heavy soiling with brown food debris underneath the burners on the stove top. The floor was noted to be sticky, with black buildup in front of the oven and dishwasher. The cupboards storing cups and plates for resident use were observed to have soiled exteriors and handle surfaces. During observation on 6/28/16, at 9:24 a.m. the Angel Wing pantry floor was observed again with black buildup in front of the dishwasher and oven, with the sticky substance on the oven door and black buildup inside the oven still present. During observation and interview on 6/28/16, at 11:29 a.m. the dietary manager (DM) indicated the Angel Wing pantry was "absolutely not" clean. The DM indicated the dietary staff were responsible for cleaning the pantry and utilized cleaning checklists/procedures. The Benedictine Health System Pantry Cleaning Procedures, last revised 6/16, indicated the culinary services aides were responsible for the sanitation of the neighborhood pantries following each meal period including countertops, tables, floors, refrigerators, stove/ovens, microwave range and dish machine. Floors are to be swept and mopped after the lunch hour daily by culinary services aide and swept after the dinner hour by the culinary services aide.	F 465	2. Identifion of other potential residents being affected will include audits and monitoring of pantry neighborhoods for cleanliness and sanitation. Pantry Cleaning Procedure Education was provided to staff members involved and procedural requirements on 6/28/16. An department training of policy and procedure will be held on 7/31/16. 3. The policy and procedure was updated on 6/28/16. 4. Corrective action will be completed 7/31/16 upon completion of department staff training. The deficiency was reviewed at the facilities Quality Council meeting on 7/21/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**06/29/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on June 29, 2016. At the time of this survey, Benedictine Living Community of St. Peter was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. Benedictine Living Community of St. Peter was constructed in 2006 at two different times. The original building is a one story building with no basement of Type V(111) construction. The addition constructed in 2006, with a link to the hospital is a one story building with no basement of Type V(111) construction. The building is fully fire sprinkler protected. The nursing home is separated from a hospital and a senior housing facility by 2-hour fire wall assemblies, with opening protectives consisting of labeled, self-closing, positive latching, 90-minute fire rated door assemblies.The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility also has automatic smoke detection in all sleeping rooms. Because the original building and the addition meet the construction type allowed for new buildings, the 2 buildings will be surveyed as one building. The facility has a capacity of 74 beds and had a census of 69 at time of the survey.	K 000		

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

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.

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
July 12, 2016

Ms. Linda Nelsen, Administrator
Benedictine Living Community
1907 Klein Street
St Peter, MN 56082

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5501026 and Complaint Number H5501013

Dear Ms. Nelsen:

The above facility was surveyed on June 27, 2016 through June 29, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5501013 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00399	A. BUILDING: _____ B. WING _____	06/29/2016

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BENEDICTINE LIVING COMMUNITY	1907 KLEIN STREET ST PETER, MN 56082

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 06/27/2016-06/29/2016 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 In addition, a complaint investigation was completed for #H5501013, which was unsubstantiated.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure services were coordinated with the hospice provider for 1 of 1 resident (R143) reviewed for hospice. Findings include: R143 was admitted on 4/29/16, with diagnoses per the care plan dated 5/19/16, including: Palliative care, malignant neoplasm of rectum, malignant neoplasm of renal pelvis, carcinoma of liver, gallbladder, bronchus and lung; severe protein calorie malnutrition, colostomy complication-fistula, shortness of breath requiring	2 830	Acknowledged	7/21/16

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2 830	Continued From page 3 oxygen and nausea with vomiting. The admission Minimum Data Set (MDS) assessment dated 5/7/15, identified R143 with a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. The assessment further identified R143 as at risk for a pressure ulcer (PU). A Tissue Tolerance Assessment dated 4/30/16, identified the coccyx as pink and blanches, after lying on back;-no redness to other bony prominence's. R143 had no open areas related to pressure documented on the admission assessment. Review of the document titled Pressure Sore/ Stasis Ulcer dated 5/12/16, at 4:50 a.m. identified a Stage I pressure ulcer (PU)- persistent area of skin redness, without a break in the skin, that does not disappear when pressure is relieved. Surrounding tissue is indurated, macerated, erythema present. R143 was experiencing mild pain identified as uncomfortable and annoying. The document further identified contributing factors which included decreased food intake, weight loss and PU history. The care plan dated 5/19/16, also identified R143 at risk for PU due to friction, sheer, nutrition, activity, and chair fast; on hospice benefit and takes very little nutrition due to disease process. The hospice care plan titled IDT (interdisciplinary team) Care Plan dated 4/29/16 to 7/27/16, indicated the patient [R143] will demonstrate compliance with wound care regimen and identified the following: (1.) Monitor skin for redness, warmth, and integrity with each skilled nurse visit; (2.) Assess wound location, drainage, surrounding skin, pain effectiveness of treatment, wound bed color and size; (3.) Wound care both sides of coccyx: apply Mepilex daily	2 830		

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2 830	Continued From page 4 and PRN (as needed); and (4.) Wound care right ischium. Apply Mepilex every 3 days and PRN soiled or loose, (added on 5/20/16). Documentation in the record identified a fax dated 5/12/16, which included: "the resident has a new pressure sore to left of coccyx which measures 1.5 x 2 cm and it looks purplish/black. Skin red on bottom, skin mostly intact. There was a new order for a Mepilex dressing change every 3 days". The order from the nurse practitioner (NP) dated 5/16/16, indicated: coccyx wound orders- clean with wound wash. apply barrier cream and island dressing and or 4 x 4 Mepilex. Change daily and as needed. Review of R143's Treatment Administration History revealed the coccyx wound dressing was changed every third day and monitoring of the redness to the bottom was initialed every shift. Documentation in the record was lacking to indicate a nursing assessment had been conducted related to the condition and measurements of the wound by facility and/or the hospice nursing staff. Review of the nursing progress notes identified the following: -6/15/16-Resident complained of her buttock being sore from her mattress. Resident states, "I have to find the right groove to make it comfortable", call placed to hospice and they will bring a pressure reducing mattress for her tomorrow; -6/22/16- did cleanse the wound with saline and apply new Mepilex border on coccyx wound which is a stage 2-3. Most of the wound bed is yellow/green in color. Wound does have some odor. A second Mepilex applied on right ischial area which is stage two; and	2 830		

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2 830	Continued From page 5 -6/29/16-Wound has very foul smell when dressing is removed and old dressing saturated with purulent drainage. Wound on coccyx measures 4.5 x 5 cm (centimeters) and is 0.3 cm at deepest point. Wound bed is 100% yellow slough. Black necrotic tissue noted at wound edge at 7 o'clock. Necrotic area measures 1 cm 0.3 cm. Second wound on left buttock below coccyx measures 2.8 x 2.5 cm. Wound bed is red and superficial. Skin surrounding wounds is red and intact. When interviewed on 6/28/16, at 9:30 a.m. registered nurse (RN)-A stated that R143's Mepilex dressing is changed every 3 days in the evening and was last changed on 6/27/16. RN-A stated she had not recently viewed the wound and confirmed a wound assessment had not been completed since 5/11/16. RN-A verified this after a review of the electronic medical record. When interviewed on 6/28/16, at 2:55 p.m. the director of nursing (DON) stated she had been in contact with the hospice provider. The DON stated the hospice nurse indicated she did not believe that they [hospice] needed to measure and monitor pressure ulcers. Interventions listed in the 4/29/16, hospice care plan related to the PU were reviewed with the DON and included the following: (1.) Monitor skin for redness, warmth, and integrity with each skilled nurse visit; and (2.) Assess wound location, drainage, surrounding skin, pain effectiveness of treatment, wound bed color and size. The DON replied, "that's interesting, she will want to talk with you when she arrives." [Referencing the hospice nurse]. When interviewed on 6/28/16, at 3:51 p.m. hospice nurse RN-B confirmed that review of the hospice record omitted assessment and PU	2 830		

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2 830	Continued From page 6 documentation. There was one entry on 6/8/16 and 6/22/15 by hospice nurse. RN-B stated she would review with the hospice team the necessity for assessment, monitoring, and intervention of the pressure wounds at least weekly. A lack of coordination of care between the facility staff and hospice was evident. The policy titled Hospice Program reviewed 6/2016, included: (4.) If hospice becomes involved in the care of the resident: (d.) The hospice retains overall responsibility for directing and coordinating the plan of care related to the terminal illness and related conditions such as wound care. SUGGESTED METHOD OF CORRECTION: The DON or designee could educate all appropriate staff on the colaboration of Hospice care. The quality assessment and assurance committee could develop a monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician	2 900		7/21/16

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2 900	Continued From page 7 authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, document review and interview the facility failed to provide ongoing monitoring, assessment and intervention to reduce the risk of further development or deterioration of a pressure ulcer for 1 of 1 (R143) resident reviewed with a pressure ulcer. Findings include: R143 was admitted on 4/29/16, with diagnoses per the care plan dated 5/19/16, including: Palliative care, malignant neoplasm of rectum, malignant neoplasm of renal pelvis, carcinoma of liver, gallbladder, bronchus and lung; severe protein calorie malnutrition, colostomy complication-fistula and shortness of breath requiring oxygen. The admission Minimum Data Set (MDS) assessment dated 5/7/15, identified R143 with a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. The assessment further identified R143 as at risk for a pressure ulcer (PU). A Tissue Tolerance Assessment dated 4/30/16, identified the coccyx as pink and blanches, after lying on back;-no redness to other bony prominence's. R143 had no open areas related to pressure documented on the admission assessment.	2 900	Acknowledged	

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2 900	Continued From page 8 Review of the document titled Pressure Sore/ Stasis Ulcer dated 5/12/16, at 4:50 a.m. identified a Stage I pressure ulcer (PU)- persistent area of skin redness, without a break in the skin, that does not disappear when pressure is relieved. Surrounding tissue is indurated, macerated, erythema present. R143 was experiencing mild pain identified as uncomfortable and annoying. The document further identified contributing factors which included decreased food intake, weight loss and PU history. The care plan dated 5/19/16, also identified R143 at risk for PU due to friction, sheer, nutrition, activity, and chair fast; on hospice benefit and takes very little nutrition due to disease process. The hospice care plan titled IDT (interdisciplinary team) Care Plan dated 4/29/16 to 7/27/16, indicated the patient [R143] will demonstrate compliance with wound care regimen and identified the following: (1.) Monitor skin for redness, warmth, and integrity with each skilled nurse visit; (2.) Assess wound location, drainage, surrounding skin, pain effectiveness of treatment, wound bed color and size; (3.) Wound care both sides of coccyx: apply Mepilex daily and PRN (as needed); and (4.) Wound care right ischium. Apply Mepilex every 3 days and PRN soiled or loose, (added on 5/20/16). Documentation in the record identified a fax dated 5/12/16, which included: "the resident has a new pressure sore to left of coccyx which measures 1.5 x 2 cm and it looks purplish/black. Skin red on bottom, skin mostly intact. There was a new order for a Mepilex dressing change every 3 days". The order from the nurse practitioner (NP) dated 5/16/16, indicated: coccyx wound orders- clean with wound wash. apply barrier cream and island	2 900		

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	00399	A. BUILDING: _____ B. WING _____	06/29/2016

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2 900	Continued From page 9 dressing and or 4 x 4 Mepilex. Change daily and as needed. Review of R143's Treatment Administration History revealed the coccyx wound dressing was changed every third day and monitoring of the redness to the bottom was initialed every shift. Documentation in the record was lacking to indicate a nursing assessment had been conducted related to the condition and measurements of the wound by facility and/or the hospice nursing staff. Review of the nursing progress notes identified the following: -6/15/16-Resident complained of her buttock being sore from her mattress. Resident states, "I have to find the right groove to make it comfortable", call placed to hospice and they will bring a pressure reducing mattress for her tomorrow; -6/22/16- did cleanse the wound with saline and apply new Mepilex border on coccyx wound which is a stage 2-3. Most of the wound bed is yellow/green in color. Wound does have some odor. A second Mepilex applied on right ischial area which is stage two; and -6/29/16-Wound has very foul smell when dressing is removed and old dressing saturated with purulent drainage. Wound on coccyx measures 4.5 x 5 cm (centimeters) and is 0.3 cm at deepest point. Wound bed is 100% yellow slough. Black necrotic tissue noted at wound edge at 7 o'clock. Necrotic area measures 1 cm 0.3 cm. Second wound on left buttock below coccyx measures 2.8 x 2.5 cm. Wound bed is red and superficial. Skin surrounding wounds is red and intact. When interviewed on 6/28/16, at 9:30 a.m.	2 900		

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2 900	Continued From page 10 registered nurse (RN)-A stated that R143's Mepilex dressing is changed every 3 days in the evening and was last changed on 6/27/16. RN-A stated she had not recently viewed the wound and confirmed a wound assessment had not been completed since 5/11/16. RN-A verified this after a review of the electronic medical record. When interviewed on 6/28/16, at 2:55 p.m. the director of nursing (DON) stated she had been in contact with the hospice provider. The DON stated the hospice nurse indicated she did not believe that they [hospice] needed to measure and monitor pressure ulcers. Interventions listed in the 4/29/16, hospice care plan related to the PU were reviewed with the DON and included the following: (1.) Monitor skin for redness, warmth, and integrity with each skilled nurse visit; and (2.) Assess wound location, drainage, surrounding skin, pain effectiveness of treatment, wound bed color and size. The DON replied, "that's interesting, she will want to talk with you when she arrives." [Referencing the hospice nurse]. When interviewed on 6/28/16, at 3:51 p.m. hospice nurse RN-B confirmed that review of the hospice record omitted assessment and PU documentation. There was one entry on 6/8/16 and 6/22/15 by hospice nurse. RN-B stated she would review with the hospice team the necessity for assessment, monitoring, and intervention of the pressure wounds at least weekly. When interviewed on 6/29/16, at 2:30 p.m. the DON stated the facility had a wound nurse that rounded weekly. The DON confirmed the wound nurse had not reviewed R143's PU when discovered. The DON verified being notified of the new PU when discovered though the information had not been communicated to the	2 900		

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2 900	Continued From page 11 wound nurse. Subsequently, the wound nurse became involved with the treatment/assessment of the PU on 6/29/16. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could review and revise the pressure ulcer protocol. In addition, the DON could provide education to the nursing staff on the importance of assessment and implementing pressure reducing interventions. The DON could develop a system for the nursing staff to monitor that interventions are implemented on a continual basis. The quality assessment and assurance committee could do random audits of pressure ulcer interventions to ensure residents are receiving the appropriate care and treatment. TIME PERIOD FOR CORRECTION: Seven (14) days.	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. 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 MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide personal assistance with shaving and dressing needs for 1 of 4 residents (R47) reviewed for activities of daily living.	2 920	Acknowledged	7/21/16

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2 920	Continued From page 12 Findings included: During observations on 6/27/16 at 3:27 p.m., 6/28/16 at 8:38 a.m. and 6/29/16 at 7:58 a.m., R47 was observed to have long thin black/gray facial hairs on her chin and upper lip which measured approximately 1/4 to 1 inch in length. R47's diagnoses per the care plan dated 4/22/16, included: muscle weakness and blindness of both eyes. R47's quarterly Minimum Data Set (MDS) dated 4/7/16, included a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating moderate cognitive impairment. The assessment also indicated R47 required extensive physical assist from one staff member for personal hygiene and for dressing. R47's care plan dated 4/22/16 included a self-care deficit in areas of dressing, bathing, and grooming. The care plan revealed "Family will assist resident with shaving any facial hair, they do not feel they need to provide a electric razor and when they visit they will pluck any facial hair". When interviewed on 6/29/16, at 7:58 a.m. R47 stated she used to take care of the facial hair herself when still at home. R47 stated staff help her now and her choice would be to have the hair removed from her chin. R47 is observed to have the same shirt on her that she had on 6/28/16. It is soiled with dried on food debris which is dripped down the front of her blouse from neckline to stomach. When interviewed on 6/29/16, at 8:49 a.m. the nurse manager (NM)-B stated R47's daughter was at the facility for R47's birthday two days ago	2 920		

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2 920	Continued From page 13 and "evidently did not take care of the facial hair." When informed R47 stated it would bother her to have facial hairs and would want them removed, NM-B confirmed there was not a plan/alternate method to provide the personal assistance with the hair removal when not completed by the family. When interviewed on 6/29/16, at 9:12 a.m. trained medication aide (TMA)-A stated staff encourage R47 to help participate with her cares. TMA-A stated staff need to assist R47 with completing simple tasks, such as combing hair and brushing teeth. TMA-A confirmed the presence of the long facial hairs and the soiled blouse. TMA-A stated staff are directed to leave the facial hair for R47's daughter to remove, and verified there was not an available razor supplied by the facility for resident use nor an alternate method. When interviewed on 6/29/16, at 12:45 p.m. the director of nursing (DON) confirmed a community razor was not provided by the facility due to infection control purposes. The DON stated family members are requested to provide razors and multiple attempts had been made for R47's family to bring in a razor. SUGGESTED METHOD OF CORRECTION: The director of nurses and/or designee could review pertinent policies and procedures related to grooming, audit resident care to ensure grooming needs are met and educate staff on the importance of grooming needs. The results of the audit could be reported during the quarterly quality assurance committee meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		

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21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 5 neighborhood pantries (Angel Wing) was maintained in a sanitary manner. This had the potential to affect 19 residents residing on the unit. Findings include: During observation on 6/27/16, at 6:34 p.m. the Angel Wing pantry oven was observed to have a light brown, sticky substance with food debris on the upper lip of the oven door, dried black debris in the bottom of the oven and heavy soiling with brown food debris underneath the burners on the stove top. The floor was noted to be sticky, with black buildup in front of the oven and dishwasher. The cupboards storing cups and plates for resident use were observed to have soiled exteriors and handle surfaces. During observation on 6/28/16, at 9:24 a.m. the Angel Wing pantry floor was observed again with black buildup in front of the dishwasher and oven, with the sticky substance on the oven door and black buildup inside the oven still present. During observation and interview on 6/28/16, at 11:29 a.m. the dietary manager (DM) indicated the Angel Wing pantry was "absolutely not" clean.	21665	Acknowledged	7/21/16

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21665	Continued From page 15 The DM indicated the dietary staff were responsible for cleaning the pantry and utilized cleaning checklists/procedures. The Benedictine Health System Pantry Cleaning Procedures, last revised 6/16 indicated the culinary services aides were responsible for the sanitation of the neighborhood pantries following each meal period including countertops, tables, floors, refrigerators, stove/ovens, microwave range and dish machine. Floors are to be swept and mopped after the lunch hour daily by culinary services aide and swept after the dinner hour by the culinary services aide. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with dietary staff to conduct routine periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		