DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
	MEDIC	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: 6DLY
	PART I -	TO BE COMPL	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00399
1. MEDICARE/MEDICAID PROVID	ER	3. NAME AND AD				4. TYPE OF ACTION: $\underline{7}^{(L8)}$
NO.(L1) 245501		(L3) BENEDICT (L4) 1907 KLEIN		COMMUN	ITY	1. Initial 2. Recertification
2. STATE VENDOR OR MEDICAID	NO.	(L4) 1907 KLEIN (L5) ST PETER, 1			(L6) 56082	3. Termination 4. CHOW 5. Validation 6. Complaint
(L2) 849623400				ODV	~ /	7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF ((L9) 10/01/2004	OWNERSHIP	7. PROVIDER/SU	05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
	/2016 (L34)	01 Hospital 02 SNF/NF/Dual	05 HHA 06 PRTF	09 ESKD 10 NF	14 CORF	
8. ACCREDITATION STATUS:	/2016 (L34) (L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):		Program Re Compliance			2. Technical Personnel	6. Scope of Services Limit
					3. 24 Hour RN	7. Medical Director
12. Total Facility Beds	79 (L18)	1. Ad	cceptable POC		4. 7-Day RN (Rural SN	
13.Total Certified Beds	79 (L17)	B. Not in Compl	liance with Progra	am	5. Life Safety Code	9. Beds/Room
			and/or Applied V		* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
79						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA		INCELLATION	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Kathryn Serie, Unit Super	visor	9	/27/2016	(L19)	Kamala Fiske-Downing, Health	Program Representative 9/27/2016 (L20)
PAL	RT II - TO BE	COMPLETED B	BY HCFA RE	GIONAI	OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGIBIL	JTY		PLIANCE WITH	I CIVIL		ncial Solvency (HCFA-2572)
 Facility is Eligible to F 	Participate	RIGH	ITS ACT:		 Ownership/Control Both of the Above 	ol Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible						
	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEM	1ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DAT	ГЕ	VOLUNTARY <u>00</u>	INVOLUNTARY
11/01/1987					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	n <u>OTHER</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)			(L44)			00-Active
(127)	B. Rescind St	uspension Date:				
			(L45)			
28. TERMINATION DATE:	29	9. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE	Posted 08/10/2016 Co.	
	(L32)			(L33)	DETERMINATION APPI	ROVAL

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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,

Kumala 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



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,

Kumala Fiske Downing

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION			DATE OF REVISI	Т
IDENTIFICATION NUMBER	A. Building				
245501 _{Y1}	B. Wing	Y	′2	8/8/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
BENEDICTINE LIVING COMM	JNITY	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	DATE	ITEM		DATE	ITEM		DATE
Y4	Y5	Y4		Y5	Y4		Y5
ID Prefix F0309	Correction	ID Prefix F	-0312	Correction	ID Prefix	F0314	Correction
483.25	Completed	Reg. # 48	83.25(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 F	-0465	Correction	ID Prefix		Correction
Reg. # 483.30(e)	Completed	Reg. #	83.70(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		DA	
	KS/kfd	8/22/2016			03048		8/8/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE			DA	TE
FOLLOWUP TO SURVEY 6/29/2016	COMPLETED ON		K FOR ANY UNCORREC RRECTED DEFICIENCI	CTED DEFICIEN ES (CMS-2567)	NCIES. WAS SENT TO TH]YES 🗌 NO

DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: 6DLY
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00399
1. MEDICARE/MEDICAID PROVIDER NO.(L1) 245501	2	3. NAME AND AD (L3) BENEDICT			ITY	4. TYPE OF ACTION: <u>2(</u> L8) 1. Initial 2. Recertification
2. STATE VENDOR OR MEDICAID N (L2) 849623400	0.	(L4) 1907 KLEIN (L5) ST PETER , 2			(L6) 56082	1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OV (L9) 10/01/2004	VNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEC 05 HHA	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
	/2016 ^(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	_ ` `	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):		Program Re Compliance	•		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds	79 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient Room Size
13.Total Certified Beds	79 (L18) 79 (L17)	X B. Not in Com	mliance with Pro	aram	5. Life Safety Code	9. Beds/Room
15. Total Celtified Beds	17 (EI7)		and/or Applied		* Code: B *	(L12)
14. LTC CERTIFIED BED BREAKDOW	N	United States and Stat			15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
79						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMAI	RKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Wendy Willson. HFE NE II		0	7/22/2016	(L19)	Kamala Fiske-Downing, Healtl	n Program Representative 08/05/2016 (L20)
PAR	T II - TO BE	COMPLETED H	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGIBILIT			PLIANCE WITI	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
1. Facility is Eligible to Par	ticipate				3. Both of the Above	e:
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	LTC AGREEN	MENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION 11/01/1987	BEGINNING	DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on OTHER
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	D. Descend St	spension Date:	(L44)			00-Active
	D. Reseniu St	ispension Date.	(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	. ,		30. REMARKS	
		03001				
	(1.28)	03001		(L31)		
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAI	L DATE	Posted 08/10/2016 Co.	
	(L32)			(L33)	DETERMINATION APP	ROVAL

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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:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - 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;

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor Health Regulation Division Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258 Email: <u>Kathryn.serie@state.mn.us</u> 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

Kumala Riske Downing

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

		AND HUMAN SERVICES			FOR	M APPROVED
		& MEDICAID SERVICES				<u> </u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED
		245501	B. WING		0	6/29/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	
BENEDIC	CTINE LIVING COMM	UNITY			107 KLEIN STREET I PETER, MN 56082	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 0	00		
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required of first page of the CMS-2567 ic submission of the POC will tion of compliance.				
	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with				
F 309 SS=D	completed and four	complaint H#5501013 was nd not to be substantiated. CARE/SERVICES FOR EING	F 3	09		7/21/16
	provide the necess or maintain the high mental, and psycho	receive and the facility must ary care and services to attain nest practicable physical, psocial well-being, in e comprehensive assessment				
	by: Based on observat review the facility fa	NT is not met as evidenced ion, interview and document iled to ensure services were e hospice provider for 1 of 1 iewed for hospice.			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 pair	
LABORATOR	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE	(X6) DATE
Electron	ically Signed					07/22/2016

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.

PRINTED: 07/22/2016

		& MEDICAID SERVICES	(X2) MULT	IPLE	E CONSTRUCTION		0938-039 SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245501	B. WING _			06/29/2016	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 207 KLEIN STREET		
BENEDI	CTINE LIVING COMM	UNITY					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 309	per the care plan d Palliative care, mal malignant neoplast liver, gallbladder, b protein calorie mali complication-fistula oxygen and nauses The admission Min assessment dated Brief Interview for I 12, indicating mode The assessment fut for a pressure ulce Assessment dated as pink and blanch redness to other bo no open areas rela on the admission a Review of the docu Stasis Ulcer dated a Stage I pressure skin redness, witho does not disappear Surrounding tissue erythema present. pain identified as u The document furti factors which inclus weight loss and PL The care plan date R143 at risk for PL nutrition, activity, a benefit and takes v disease process.	d on 4/29/16, with diagnoses ated 5/19/16, including: lignant neoplasm of rectum, m of renal pelvis, carcinoma of ronchus and lung; severe nutrition, colostomy a, shortness of breath requiring a with vomiting. imum Data Set (MDS) 5/7/15, identified R143 with a Mental Status (BIMS) score of erate cognitive impairment. urther identified R143 as at risk r (PU). A Tissue Tolerance 4/30/16, identified the coccyx es, after lying on back;-no ony prominence's. R143 had ted to pressure documented assessment. ment titled Pressure Sore/ 5/12/16, at 4:50 a.m. identified ulcer (PU)- persistent area of out a break in the skin, that r when pressure is relieved. is indurated, macerated, R143 was experiencing mild ncomfortable and annoying. her identified contributing ded decreased food intake,	F 30	09	 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 medica record is entered and wound protocinitiated in the treatment record. 3. The Director of Nursing met with Director of the Hospice involved on 7/18/16 to coordinate communication protocol to address care plans for t agency. The Nurse Manager and Hospice Nurse will meet regularly the review the plan of care for consiste Findings were reviewed and educat provided to nursing staff at nursing meeting on 7/13/16. Review of define and plan of correction was presented facility Quality Council Meeting on 7/21/16. 4. Corrective action was comleted 7/21/16 	al col is n the on and his o ncy. tion iciency	

If continuation sheet Page 2 of 15

CENTER STATEMENT AND PLAN C NAME OF F BENEDIC	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245501 NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		A. BUILDING B. WING 1 1 5 10	LE CONSTRUCTION	FORM <u>OMB NO.</u> (X3) DAT CON 06/	: 07/22/2016 APPROVED .0938-0391 E SURVEY IPLETED 29/2016
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DATE
F 309	4/29/16 to 7/27/16, will demonstrate co regimen and identif skin for redness, wa skilled nurse visit; (1 drainage, surroundi treatment, wound b care both sides of c and PRN (as neede ischium. Apply Mep soiled or loose, (add Documentation in th 5/12/16, which inclu pressure sore to lef 1.5 x 2 cm and it loo bottom, skin mostly for a Mepilex dress The order from the 5/16/16, indicated: with wound wash. a dressing and or 4 x as needed. Review of R143's T History revealed the changed every third redness to the botto Documentation in th indicate a nursing a conducted related t measurements of th hospice nursing sta Review of the nursi the following: -6/15/16-Resident of	indicated the patient [R143] impliance with wound care ied the following: (1.) Monitor armth, and integrity with each 2.) Assess wound location, ing skin, pain effectiveness of bed color and size; (3.) Wound coccyx: apply Mepilex daily ed); and (4.) Wound care right bilex every 3 days and PRN ded on 5/20/16). the record identified a fax dated uded: "the resident has a new ft of coccyx which measures oks purplish/black. Skin red on v intact. There was a new order ing change every 3 days". nurse practitioner (NP) dated coccyx wound orders- clean apply barrier cream and island a 4 Mepilex. Change daily and the coccyx wound dressing was d day and monitoring of the om was initialed every shift. he record was lacking to assessment had been to the condition and he wound by facility and/or the aff.	F 309			

If continuation sheet Page 3 of 15

TATEMENT	OF DEFICIENCIES	A MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED		
		245501	B. WING			06/29/2016		
NAME OF	PROVIDER OR SUPPLIER		D: 11110 _	STREET ADDRESS, CITY, STATE, ZIP CODE	00	0/29/2016		
	CTINE LIVING COMM			1907 KLEIN STREET ST PETER, MN 56082				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE		
F 309	bring a pressure re tomorrow; -6/22/16- did clean apply new Mepilex is a stage 2-3. Mos yellow/green in col odor. A second Me area which is stage -6/29/16-Wound ha dressing is remove with purulent drain measures 4.5 x 5 c at deepest point. V slough. Black necr edge at 7 o'clock. I 0.3 cm. Second we coccyx measures 2	blaced to hospice and they will educing mattress for her se the wound with saline and border on coccyx wound which st of the wound bed is or. Wound does have some pplex applied on right ischial	F 30	09				
	registered nurse (F Mepilex dressing is evening and was la stated she had not and confirmed a w been completed si after a review of th When interviewed director of nursing contact with the ho stated the hospice believe that they [h and monitor press	on 6/28/16, at 9:30 a.m. RN)-A stated that R143's s changed every 3 days in the ast changed on 6/27/16. RN-A recently viewed the wound ound assessment had not nce 5/11/16. RN-A verified this e electronic medical record. on 6/28/16, at 2:55 p.m. the (DON) stated she had been in pspice provider. The DON nurse indicated she did not nospice] needed to measure ure ulcers. Interventions listed pice care plan related to the						

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		AND HUMAN SERVICES			FORM	07/22/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245501	B. WING _		06/	29/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1907 KLEIN STREET		
BENEDIC		UNITY		ST PETER, MN 56082		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		D BE	(X5) COMPLETION DATE
F 309 F 312 SS=D	Assess wound loca skin, pain effectiver color and size. The interesting, she will she arrives." [Refe When interviewed of hospice nurse RN-H hospice record omi documentation. The and 6/22/15 by hos would review with th for assessment, mo the pressure wound coordination of care hospice was evider The policy titled Ho 6/2016, included: (4 involved in the care hospice retains over and coordinating th terminal illness and wound care. 483.25(a)(3) ADL C DEPENDENT RES A resident who is un daily living receives maintain good nutri and oral hygiene.	ach skilled nurse visit; and (2.) tion, drainage, surrounding ness of treatment, wound bed DON replied, "that's want to talk with you when rencing the hospice nurse]. on 6/28/16, at 3:51 p.m. B confirmed that review of the tted assessment and PU ere was one entry on 6/8/16 pice nurse. RN-B stated she he hospice team the necessity onitoring, and intervention of ds at least weekly. A lack of e between the facility staff and nt. spice Program reviewed 4.) If hospice becomes e of the resident: (d.) The erall responsibility for directing e plan of care related to the I related conditions such as CARE PROVIDED FOR IDENTS nable to carry out activities of the necessary services to tion, grooming, and personal	F 3	309		7/21/16
	by:	NT is not met as evidenced tion, interview and document		1. Chin hairs and soiled clothing	were	

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STATEMEN	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	<u>. 0938-039</u> E SURVEY IPLETED	
		245501			06/	29/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/	25/2010	
BENEDI	CTINE LIVING COMM	UNITY		1907 KLEIN STREET ST PETER, MN 56082			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 312	review the facility fa assistance with sha of 4 residents (R47 living. Findings included: During observation 6/28/16 at 8:38 a.m R47 was observed facial hairs on her measured approxin R47's diagnoses p included: muscle w both eyes. R47's quarterly Mir 4/7/16, included a Status (BIMS) scor moderate cognitive also indicated R47 assist from one sta hygiene and for dra R47's care plan da self-care deficit in a grooming. The care assist resident with do not feel they ne and when they visit When interviewed stated she used to herself when still a her now and her ch removed from her	ailed to provide personal aving and dressing needs for 1 7) reviewed for activities of daily as on 6/27/16 at 3:27 p.m., n. and 6/29/16 at 7:58 a.m., to have long thin black/gray chin and upper lip which mately 1/4 to 1 inch in length. er the care plan dated 4/22/16, weakness and blindness of himum Data Set (MDS) dated Brief Interview for Mental re of 9 out of 15, indicating a impairment. The assessment required extensive physical aff member for personal	F 31	 addressed for Resident #47 on Grooming procedures were r with nursing staff members at n meeting on 7/13/16. New procedure was initiated residents will be asked regularly or not they want facial hair remo- regardless of family opinion. Nu Managers will audit weekly. The deficiency and plan of correction reviewed at the Quality Council on 7/21/16. Corrective action was comple 7/21/16. 	reviewed ursing that all whether oved urse e n was meeting		

If continuation sheet Page 6 of 15

		& MEDICAID SERVICES			OMB NO	/ APPROVED). 0938-039 ⁻
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245501	B. WING		06	6/29/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE	
BENEDIC	TINE LIVING COMM	UNITY		1907 KLEIN STREET ST PETER, MN 56082		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 312	Continued From pa	ige 6	F3	12		
	dripped down the front of her blouse from neckline to stomach.					
	nurse manager (NM was at the facility for and "evidently did r When informed R4 have facial hairs an NM-B confirmed the method to provide the	on 6/29/16, at 8:49 a.m. the <i>I</i>)-B stated R47's daughter or R47's birthday two days ago not take care of the facial hair." 7 stated it would bother her to ad would want them removed, ere was not a plan/alternate the personal assistance with hen not completed by the				
	trained medication encourage R47 to H TMA-A stated staff completing simple to and brushing teeth. presence of the lon blouse. TMA-A sta the facial hair for R verified there was r	on 6/29/16, at 9:12 a.m. aide (TMA)-A stated staff help participate with her cares. need to assist R47 with tasks, such as combing hair TMA-A confirmed the g facial hairs and the soiled ted staff are directed to leave 47's daughter to remove, and not an available razor supplied sident use nor an alternate				
F 314 SS=D	director of nursing of razor was not provi infection control put family members are and multiple attemp family to bring in a 483.25(c) TREATM		F3	14		7/21/16
	Based on the comp	prehensive assessment of a				

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		AND HUMAN SERVICES				FORM	07/22/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245501	B. WING	i		06/2	29/2016
	PROVIDER OR SUPPLIER	UNITY		1	TREET ADDRESS, CITY, STATE, ZIP CODE 907 KLEIN STREET 5T PETER, MN 56082		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 314	who enters the facil does not develop p individual's clinical they were unavoida pressure sores rece services to promote prevent new sores This REQUIREMEN by: Based on observat interview the facility provide ongoing mo intervention to redu development or det for 1 of 1 (R143) re Findings include: R143 was admitted per the care plan da Palliative care, mali malignant neoplasr liver, gallbladder, bi protein calorie malir complication-fistula requiring oxygen. The admission Min assessment dated Brief Interview for M 12, indicating mode The assessment fut for a pressure ulcer Assessment dated as pink and blanche	 must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that ible; and a resident having eives necessary treatment and e healing, prevent infection and from developing. NT is not met as evidenced tion, document review and railed to onitoring, assessment and ce the risk of further rerioration of a pressure ulcer sident reviewed with a PU. I on 4/29/16, with diagnoses ated 5/19/16, including: ignant neoplasm of rectum, n of renal pelvis, carcinoma of ronchus and lung; severe 	F	314	 Measurements of resident #143 wound area was completed on 6/28/ Weekly measurements were initiated the resident's care plan on 6/28/16 a reviewed with the Hospice RN-B. W measurements are based on the resident's willingness to participated indicated by the level of pain. If the of pain contraindicates the initiation plan of care the resident will be reproached for a more suitable time treatment. Residents at risk of pressure ulce be identified upon admission with sk risks. Nurse Manager will care plan accordingly and educate nursing state members. If pressure ulcer noted, an event entered into medical record by the n and wound protocol will be initiated i treatment record. The Wound Nurse Nurse Manager will be notified along Nurse Practitioner and/or Clinical W Nurse to develop treatment plan. Th Wound Nurse will round weekly and 	/16. d on and /eekly l as level of the for ers will ff will be in the e and g with ound he	

Facility ID: 00399

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY
		245501			06/	29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/	
BENEDI	CTINE LIVING COMM	UNITY		1907 KLEIN STREET ST PETER, MN 56082		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 314	on the admission a Review of the docu Stasis Ulcer dated a Stage I pressure skin redness, witho does not disappear Surrounding tissue erythema present. pain identified as u The document furth factors which inclue weight loss and PU The care plan date R143 at risk for PU nutrition, activity, ar benefit and takes v disease process. T IDT (interdisciplinar 4/29/16 to 7/27/16, will demonstrate co regimen and identifi skin for redness, w skilled nurse visit; (drainage, surround treatment, wound b care both sides of c and PRN (as needer ischium. Apply Mep soiled or loose, (ad Documentation in t 5/12/16, which inclu pressure sore to lef 1.5 x 2 cm and it lo	ted to pressure documented ssessment. ment titled Pressure Sore/ 5/12/16, at 4:50 a.m. identified ulcer (PU)- persistent area of out a break in the skin, that when pressure is relieved. is indurated, macerated, R143 was experiencing mild ncomfortable and annoying. her identified contributing ded decreased food intake, history. d 5/19/16, also identified due to friction, sheer, nd chair fast; on hospice ery little nutrition due to The hospice care plan titled ry team) Care Plan dated indicated the patient [R143] ompliance with wound care fied the following: (1.) Monitor armth, and integrity with each 2.) Assess wound location, ing skin, pain effectiveness of bed color and size; (3.) Wound coccyx: apply Mepilex daily ed); and (4.) Wound care right bilex every 3 days and PRN ded on 5/20/16). he record identified a fax dated uded: "the resident has a new ft of coccyx which measures oks purplish/black. Skin red on r intact. There was a new order	F 31	 measurements of affected area. The deficiency was reviewed education provided to nursing stamembers at the nursing meeting 7/13/16 and at the Quality Counce meeting on 7/21/16. Corrective a was completed on 7/21/16. 	aff on il	

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II	TIPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY
-	OF CORRECTION	IDENTIFICATION NUMBER:		DING		MPLETED
		245501	B. WING			6/29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
BENEDI	CTINE LIVING COMM	JNITY		1907 KLEIN STREET ST PETER, MN 56082		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE	(X5) COMPLETIO DATE
F 314	The order from the 5/16/16, indicated: with wound wash. a dressing and or 4 x as needed. Review of R143's T History revealed the changed every third redness to the botto Documentation in the indicate a nursing a conducted related the measurements of the hospice nursing state Review of the nursing the following: -6/15/16-Resident of being sore from her have to find the righ comfortable", call pl bring a pressure red tomorrow; -6/22/16- did cleans apply new Mepilex H is a stage 2-3. Most yellow/green in colo odor. A second Mep area which is stage -6/29/16-Wound ha dressing is removed with purulent draina measures 4.5 x 5 cl at deepest point. W slough. Black necroid edge at 7 o'clock. N 0.3 cm. Second work	nurse practitioner (NP) dated coccyx wound orders- clean pply barrier cream and island 4 Mepilex. Change daily and reatment Administration coccyx wound dressing was day and monitoring of the on was initialed every shift. he record was lacking to ssessment had been o the condition and he wound by facility and/or the ff. ng progress notes identified complained of her buttock mattress. Resident states, "I at groove to make it laced to hospice and they will ducing mattress for her se the wound with saline and porder on coccyx wound which t of the wound bed is or. Wound does have some pilex applied on right ischial		314		

Facility ID: 00399

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	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	à	CO	MPLETED
		245501	B. WING			/29/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1907 KLEIN STREET	E	
BENEDIC	CTINE LIVING COMM	UNITY		ST PETER, MN 56082		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 314	Continued From pa and superficial. Ski and intact.	age 10 In surrounding wounds is red	F 314	ŀ		
	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.					
	director of nursing contact with the ho stated the hospice believe that they [h and monitor pressu in the 4/29/16, hos PU were reviewed following: (1.) Mon and integrity with e Assess wound loca skin, pain effective color and size. The interesting, she will	on 6/28/16, at 2:55 p.m. the (DON) stated she had been in spice provider. The DON nurse indicated she did not ospice] needed to measure are ulcers. Interventions listed pice care plan related to the with the DON and included the itor skin for redness, warmth, ach skilled nurse visit; and (2.) ation, drainage, surrounding ness of treatment, wound bed b DON replied, "that's want to talk with you when erencing the hospice nurse].				
	hospice nurse RN- hospice record om documentation. Th and 6/22/15 by hos would review with t	on 6/28/16, at 3:51 p.m. B confirmed that review of the itted assessment and PU ere was one entry on 6/8/16 spice nurse. RN-B stated she he hospice team the necessity onitoring, and intervention of ds at least weekly.				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY MPLETED
		245501	B. WING _		06/	/29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		20/2010
BENEDI	CTINE LIVING COMM	UNITY		1907 KLEIN STREET ST PETER, MN 56082		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 314 F 356 SS=C	nurse had not revie discovered. The DC the new PU when c information had not wound nurse. Subs became involved w of the PU on 6/29/1 The policy titled Ho 6/2016, included: (4 involved in the care hospice retains ove and coordinating th terminal illness and wound care. 483.30(e) POSTED INFORMATION The facility must pc a daily basis: o Facility name. o The current date. o The total number by the following cat unlicensed nursing resident care per sl - Registered nu - Licensed prace vocational nurses (- Certified nurse o Resident census. The facility must pc specified above on of each shift. Data o Clear and readab	he DON confirmed the wound wed R143's PU when DN verified being notified of liscovered though the been communicated to the sequently, the wound nurse ith the treatment/assessment 6. spice Program reviewed 4.) If hospice becomes of the resident: (d.) The erall responsibility for directing e plan of care related to the related conditions such as D NURSE STAFFING ost the following information on and the actual hours worked egories of licensed and staff directly responsible for nift: rses. tical nurses or licensed as defined under State law). e aides.	F 31			7/21/16

Facility ID: 00399

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE	E SURVEY PLETED
		245501	B. WING			06/2	29/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	CTINE LIVING COMM	JNITY			907 KLEIN STREET T PETER, MN 56082		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 356	make nurse staffing for review at a cost standard. The facility must ma staffing data for a m required by State la This REQUIREMEN by: Based on observat review, the facility fa census and nursing had the potential to at the facility as wel Findings include: During initial tour of p.m. a Daily Staffing posted on a wall to The Daily Staffing F days earlier), and in When interviewed of administrator stateo 69. On 6/27/16, at 1:48	rs. pon oral or written request, data available to the public not to exceed the community aintain the posted daily nurse hinimum of 18 months, or as w, whichever is greater. IT is not met as evidenced ion, interview and document ailed to post the current hours on a daily basis. This affect all 69 residents residing I as family/visitors. facility on 6/27/16, at 12:05 g Form dated 6/24/16 was the left of the entrance door. Form was dated 6/24/16 (3 idicated a census of 70. on 6/27/16, at 1:45 p.m. the I the current census was only p.m. the Daily Staffing Form ve been updated to reflect	F 3	856	 DEFICIENCY) The daily staffing form was updated on 6/27/16. The Director of Nursing reviewed process of posting the schedule with nursing management team, HIC, HL and Administrator to assure a current schedule is posted. On daily basis the Director of Nur and HUC will have the updated form posted with current date, facility namnumber of actual hours worked by category and resident census. This includes a nursing staff member ass to update the daily staffing form. Corrective action was completed 7/21/16 after initiation of plan of correction, review and notification of deficiency with nursing staff member 	I the the JC at rsing ne, signed on	
	health information of	on 6/29/16, at 10:12 a.m. the coordinator (HIC) indicated she dating the Daily Staffing Form			nursing meeting on 7/13/16 and at the facility Quality Council meeting on 7/21/16.		

Facility ID: 00399

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PRINTED: 07/22/2016

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()		DATE SURVEY COMPLETED
		245501	B. WING		06/29/2016
NAME OF I	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	
BENEDI	CTINE LIVING COMM	UNITY		1907 KLEIN STREET ST PETER, MN 56082	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 356	and stated she upd through Friday "firs needed. The HIC f updates nor chang weekends. She co Form observed dur been updated from inaccurate census. When interviewed director of nursing Daily Staffing Form	age 13 ates the posting daily Monday t thing in the morning", and as urther indicated no one es the posting on the nfirmed the Daily Staffing ing the initial tour had not the weekend and reflected an on 6/29/16, at 10:12 a.m. the (DON) confirmed the facility is not updated or changed ds stating "we just don't have	F 35	5	
F 465 SS=B	483.70(h) SAFE/FUNCTIONA E ENVIRON The facility must pr	AL/SANITARY/COMFORTABL ovide a safe, functional, ortable environment for the public.	F 46	5	7/31/16
	by: Based on observa review, the facility f neighborhood pant maintained in a sar potential to affect 1 unit. Findings include: During observation Angel Wing pantry light brown, sticky s	NT is not met as evidenced tion, interview and document ailed to ensure 1 of 5 ries (Angel Wing) was nitary manner. This had the 9 residents residing on the on 6/27/16, at 6:34 p.m. the oven was observed to have a substance with food debris on oven door, dried black debris		1. Immediate cleaning of unsanitary a in Angel pantry where deficient area wa 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 tha was indicated was cleaned thoroughly will continue to be maintained in a sani- manner. All other contact surfaces we cleaned immediately as well and will continue to be cleaned and maintained a sanitary manner.	as at and ary 'e

Facility ID: 00399

If continuation sheet Page 14 of 15

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/22/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	SURVEY PLETED
		245501	B. WING			06/2	29/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI		UNITY			007 KLEIN STREET T PETER, MN 56082		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	in the bottom of the brown food debris us stove top. The floo black buildup in from The cupboards stor resident use were of exteriors and handl During observation Angel Wing pantry black buildup in from with the sticky subs black buildup inside During observation 11:29 a.m. the dieta the Angel Wing par The DM indicated th responsible for clea cleaning checklists/ The Benedictine He Procedures, last re- culinary services air sanitation of the ne each meal period ir floors, refrigerators range and dish made and mopped after the	oven and heavy soiling with inderneath the burners on the r was noted to be sticky, with nt of the oven and dishwasher. ing cups and plates for observed to have soiled e surfaces. on 6/28/16, at 9:24 a.m. the floor was observed again with nt of the dishwasher and oven, tance on the oven door and e the oven still present. and interview on 6/28/16, at ary manager (DM) indicated itry was "absolutely not" clean. he dietary staff were uning the pantry and utilized (procedures. ealth System Pantry Cleaning vised 6/16, indicated the des were responsible for the ighborhood pantries following ncluding countertops, tables, , stove/ovens, microwave chine. Floors are to be swept he lunch hour daily by culinary wept after the dinner hour by	F 4	65	 Identifion of other potential reside being affected will include audits and monitoring of pantry neighborhoods cleanliness and sanitation. Pantry Cleaning Procedure Education was provided to staff members involved procedural requirements on 6/28/16 department training of policy and procedure will be held on 7/31/16. The policy and procedure was up on 6/28/16. Corrective action will be complete 7/31/16 upon completion of departm staff training. The deficiency was reviewed at the facilities Quality Council meeting on 7/21/16. 	d for and . An odated ed nent	

Facility ID: 00399

If continuation sheet Page 15 of 15

	MENT OF HEALTH			Ŧ	5501024	•)7/01/2016 PPROVED)938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		1	PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		245501				06/29/2	2016
	ROVIDER OR SUPPLIER	MUNITY	1907 KI	RESS, CITY, S LEIN STRE ER, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL I INTIFYING INFORMATION)		ID PREFIX TAG	EROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	Minnesota Departm Fire Marshal Division time of this survey, of St. Peter was four compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National (NFPA) Standard 1 Chapter 18 New He Benedictine Living constructed in 2000 original building is a basement of Type addition constructer hospital is a one st of Type V(111) con The building is full nursing home is se senior housing faci assemblies, with o of labeled, self-clos 90-minute fire rate has a fire alarm sy the corridors and s which is monitored notification. The fa smoke detection in the original building construction type a buildings will be su facility has a capac census of 69 at time	Survey was conduct nent of Public Safety on, on June 29, 2016 Benedictine Living C and to be in substant e requirements for pa aid at 42 CFR, Subpa ety from Fire, and the Fire Protection Assoc 01, Life Safety Code ealth Care Occupand Community of St. Pe 5 at two different time a one story building v V(111) construction. d in 2006, with a link ory building with no to struction. y fire sprinkler protect parated from a hosp lity by 2-hour fire wa pening protectives co sing, positive latching d door assemblies. T stem with smoke def paces open to the co for automatic fire def acility also has autom all sleeping rooms. g and the addition me allowed for new build irveyed as one buildi city of 74 beds and h he of the survey.	, State 5. At the Community ial articipation art = 2000 ciation (LSC), cies. eter was es. The with no The to the basement cted. The ital and a ll onsisting g, he building rection in partment hatic Because eet the ings, the 2 ng. The ad a	K 000			
LABORAT	ORY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRES	ENTATIVE'S SIG	GNATURE	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.



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 <u>only a suggestion</u> 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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,

Kumala Fiske Downing

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

Minneso	ta Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00399	B. WING		06/2	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE LIVING COMM		N STREET R, MN 56082			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet <http: td="" www.health.<=""><td>participate in the electronic nsure orders consistent with artment of Health in 14-01, available at state.mn.us/divs/fpc/profinfo/in ate licensing orders are</td><td></td><td></td><td></td><td></td></http:>	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at state.mn.us/divs/fpc/profinfo/in ate licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 07/22/16

STATE FORM

If continuation sheet 1 of 16

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00399	B. WING		06/	29/2016	
	PROVIDER OR SUPPLIER	1907 k	ADDRESS, CITY, STATE, ZIP CODE				
BENEDIC	CTINE LIVING COMM		TER, MN 56082				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 000	Continued From pa	age 1	2 000				
	you electronically. is necessary for St enter the word "con text. You must ther State licensure pro completion date, th	alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rrected" in the box available for indicate in the electronic incess, under the heading the date your orders will be electronically submitting to the ment of Health.	on				
	Department's staff the following correct Please indicate in y correction that you	29/2016 surveyors of this , visited the above provider a ction orders are issued. your electronic plan of have reviewed these orders te when they will be complete	,				
	the State Licensing federal software. T	nent of Health is documentin g Correction Orders using ag numbers have been sota state statutes/rules for	g				
	column entitled "IE statute/rule out of o "Summary Stateme and replaces the "" correction order. T findings which are after the statement evidence by." Follo	number appears in the far lef D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statut t, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.					
	FOURTH COLUMI "PROVIDER'S PLA APPLIES TO FEDI	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THI ERAL DEFICIENCIES ONLY AR ON EACH PAGE.	s				

	ta Department of He				
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (XS) DATE SURVEY COMPLETED
		00399	B. WING		06/29/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
BENEDIC	CTINE LIVING COMM	IINITY	EIN STREET	0	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 000	Continued From pa	ige 2	2 000		
	In addition, a comp completed for #H55 unsubstantiated.	laint investigation was 501013, which was			
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830		7/21/16
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on id preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident in bed.	1		
	by: Based on observat review the facility fa	ent is not met as evidenced ion, interview and document ailed to ensure services were e hospice provider for 1 of 1 riewed for hospice.		Acknowledged	
	Findings include:				
	per the care plan d Palliative care, mal malignant neoplasr liver, gallbladder, b protein calorie malr	l on 4/29/16, with diagnoses ated 5/19/16, including: ignant neoplasm of rectum, n of renal pelvis, carcinoma of ronchus and lung; severe nutrition, colostomy I, shortness of breath requiring			

TATEMEN	ta Department of H IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00399	B. WING		06/	29/2016
AME OF I	PROVIDER OR SUPPLIEF	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	• • • •	
ENEDI	CTINE LIVING COM		EIN STREET R, MN 56082			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From p	age 3	2 830			
	oxygen and nause	ea with vomiting.				
	assessment dated Brief Interview for 12, indicating mod The assessment f for a pressure ulca Assessment dated as pink and blanch redness to other b	nimum Data Set (MDS) d 5/7/15, identified R143 with a Mental Status (BIMS) score of lerate cognitive impairment. urther identified R143 as at risk er (PU). A Tissue Tolerance d 4/30/16, identified the coccyx hes, after lying on back;-no bony prominence's. R143 had ated to pressure documented assessment.				
	Stasis Ulcer dated a Stage I pressure skin redness, with does not disappea Surrounding tissue erythema present. pain identified as of The document fur	ument titled Pressure Sore/ d 5/12/16, at 4:50 a.m. identified e ulcer (PU)- persistent area of out a break in the skin, that ar when pressure is relieved. e is indurated, macerated, . R143 was experiencing mild uncomfortable and annoying. ther identified contributing uded decreased food intake, U history.				
	R143 at risk for PI nutrition, activity, a benefit and takes disease process. IDT (interdisciplina 4/29/16 to 7/27/16 will demonstrate c regimen and ident skin for redness, v skilled nurse visit; drainage, surround treatment, wound	ed 5/19/16, also identified U due to friction, sheer, and chair fast; on hospice very little nutrition due to The hospice care plan titled ary team) Care Plan dated 5, indicated the patient [R143] compliance with wound care ified the following: (1.) Monitor warmth, and integrity with each (2.) Assess wound location, ding skin, pain effectiveness of bed color and size; (3.) Wound coccyx: apply Mepilex daily				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED		
		00399	B. WING		06/29/2016			
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	DDRESS, CITY, STATE, ZIP CODE				
BENEDI	CTINE LIVING COMM		LEIN STREET TER, MN 56082					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE		
2 830	Continued From pa	age 4	2 830					
		ed); and (4.) Wound care rig pilex every 3 days and PRN Ided on 5/20/16).	ht					
	5/12/16, which incl pressure sore to le 1.5×2 cm and it lo bottom, skin mostly for a Mepilex dress The order from the 5/16/16, indicated: with wound wash.	the record identified a fax dat uded: "the resident has a new ft of coccyx which measures boks purplish/black. Skin red y intact. There was a new ord sing change every 3 days". Inurse practitioner (NP) date coccyx wound orders- clear apply barrier cream and islar < 4 Mepilex. Change daily an	w on der da n					
	History revealed th changed every thir redness to the bott Documentation in t indicate a nursing conducted related	Treatment Administration e coccyx wound dressing wa d day and monitoring of the om was initialed every shift. the record was lacking to assessment had been to the condition and the wound by facility and/or the aff.						
	the following: -6/15/16-Resident being sore from he have to find the rig comfortable", call p	ing progress notes identified complained of her buttock er mattress. Resident states, ht groove to make it placed to hospice and they w educing mattress for her	"					
	tomorrow; -6/22/16- did clean apply new Mepilex is a stage 2-3. Mos yellow/green in col	se the wound with saline and border on coccyx wound wh st of the wound bed is or. Wound does have some pilex applied on right ischial						

	ta Department of H					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			-			
		00399	B. WING		06/29/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
BENEDIC	CTINE LIVING COMM	IIINITY	EIN STREET ER, MN 56082			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 5	2 830			
	-6/29/16-Wound hadressing is remove with purulent drain measures 4.5 x 5 of at deepest point. W slough. Black necre edge at 7 o'clock. If 0.3 cm. Second wo coccyx measures 2 and superficial. Sk and intact. When interviewed registered nurse (F Mepilex dressing is evening and was lastated she had not and confirmed a w been completed si after a review of th When interviewed director of nursing contact with the hos stated the hospice believe that they [h and monitor press in the 4/29/16, hos PU were reviewed following: (1.) Mor and integrity with e Assess wound loca skin, pain effective color and size. The interesting, she will she arrives." [Reference]	as very foul smell when ed and old dressing saturated age. Wound on coccyx cm (centimeters) and is 0.3 cm Vound bed is 100% yellow otic tissue noted at wound Necrotic area measures 1 cm bund on left buttock below 2.8 x 2.5 cm. Wound bed is rea in surrounding wounds is red on 6/28/16, at 9:30 a.m. RN)-A stated that R143's is changed every 3 days in the ast changed on 6/27/16. RN-A recently viewed the wound ound assessment had not nce 5/11/16. RN-A verified this e electronic medical record. on 6/28/16, at 2:55 p.m. the (DON) stated she had been in ospice provider. The DON nurse indicated she did not iospice] needed to measure ure ulcers. Interventions listed pice care plan related to the with the DON and included the hitor skin for redness, warmth, ach skilled nurse visit; and (2. ation, drainage, surrounding ness of treatment, wound bed a DON replied, "that's I want to talk with you when erencing the hospice nurse]. on 6/28/16, at 3:51 p.m. B confirmed that review of the				
nesota D	hospice record om	itted assessment and PU				
TE FOR			6899 61	DLY11	If continua	tion sheet 6

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00399	B. WING		06/	29/2016
NAME OF I	PROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, ST	TATE, ZIP CODE		
BENEDI	CTINE LIVING COMM	IIINITY	KLEIN STREET ETER, MN 56082			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 6	2 830			
	and 6/22/15 by hos would review with t for assessment, m the pressure woun coordination of car hospice was evider The policy titled Ho 6/2016, included: (involved in the care hospice retains ove and coordinating th	ere was one entry on 6/8/16 spice nurse. RN-B stated sh the hospice team the neces onitoring, and intervention of ds at least weekly. A lack of e between the facility staff a nt. ospice Program reviewed 4.) If hospice becomes e of the resident: (d.) The erall responsibility for direction the plan of care related to the d related conditions such as	ne isity of f and ing e			
	The DON or design appropriate staff or care. The quality a committee could de ensure ongoing co	THOD OF CORRECTION: nee could educate all n the colaboration of Hospic assessment and assurance evelop a monitoring system mpliance. R CORRECTION: Twenty-c	is to			
	(21) days					
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressur	e 2 900			7/21/16
	comprehensive res of nursing services	sores. Based on the sident assessment, the direct must coordinate the nursing care plan which	ctor			
	without pressure s pressure sores unl	no enters the nursing home cores does not develop ess the individual's clinical rates, and a physician				

6DLY11

If continuation sheet 7 of 16

		A. BUILDING	:	COM	PLETED
	00399	B. WING		06/29/2016	
PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
CTINE LIVING COMM	INITY		2		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLET DATE
Continued From pa	ge 7	2 900			
authenticates, that	they were unavoidable; and				
receives necessary promote healing, pr	y treatment and services to revent infection, and prevent				
by: Based on observation, document review interview the facility failed to provide ongoing monitoring, assessmen intervention to reduce the risk of further development or deterioration of a pressu	on, document review and failed to onitoring, assessment and ce the risk of further erioration of a pressure ulcer		Acknowledged		
Findings include:					
per the care plan da Palliative care, mali malignant neoplasm liver, gallbladder, bu protein calorie malr	ated 5/19/16, including: ignant neoplasm of rectum, n of renal pelvis, carcinoma of ronchus and lung; severe nutrition, colostomy				
assessment dated Brief Interview for M 12, indicating mode The assessment fu for a pressure ulcer Assessment dated as pink and blancher redness to other bo	5/7/15, identified R143 with a Mental Status (BIMS) score of erate cognitive impairment. rther identified R143 as at risk r (PU). A Tissue Tolerance 4/30/16, identified the coccyx es, after lying on back;-no ony prominence's. R143 had				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From para authenticates, that B. a resident we receives necessary promote healing, prinew sores from dev This MN Requirement by: Based on observation interview the facility provide ongoing mo- intervention to reduce development or det for 1 of 1 (R143) re- pressure ulcer. Findings include: R143 was admitted per the care plan da Palliative care, mali- malignant neoplasmi liver, gallbladder, bri- protein calorie mali- complication-fistular requiring oxygen. The admission Min- assessment dated Brief Interview for M 12, indicating mode The assessment fur- for a pressure ulcer Assessment dated as pink and blancher redness to other bo- no open areas relationed	CTINE LIVING COMMUNITY ST PETE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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.	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Cline Living Community ST PETER, MN 56082 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 MUST Continued From page 7 2 900 Continued From page 7 2 900 2 900 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. Acknowledged This MN Requirement is not met as evidenced by: Acknowledged Acknowledged Based on observation, document review and intervention to reduce the risk of further development or deterioriation of a pressure ulcer for 1 of 1 (R143) resident reviewed with a pressure ulcer. 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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00399	B. WING	B. WING		29/2016	
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZIP CODE				
BENEDI	CTINE LIVING COMM	LINITY					
(X4) ID	SUMMARY STA		ID ID	PROVIDER'S PLAN OF (CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLE DATE	
2 900	Continued From pa	age 8	2 900				
	Stasis Ulcer dated a Stage I pressure skin redness, witho does not disappear Surrounding tissue erythema present. pain identified as u The document furth factors which includ weight loss and PU The care plan date R143 at risk for PU nutrition, activity, an benefit and takes v disease process. T IDT (interdisciplinat 4/29/16 to 7/27/16, will demonstrate cor regimen and identifi skin for redness, w skilled nurse visit; (drainage, surround treatment, wound b care both sides of o and PRN (as need ischium. Apply Mep soiled or loose, (ad Documentation in t 5/12/16, which inclu- pressure sore to let 1.5 x 2 cm and it lo bottom, skin mostly for a Mepilex dress The order from the 5/16/16, indicated:	d 5/19/16, also identified due to friction, sheer, nd chair fast; on hospice ery little nutrition due to The hospice care plan titled ry team) Care Plan dated indicated the patient [R143] ompliance with wound care fied the following: (1.) Monitor armth, and integrity with each 2.) Assess wound location, ing skin, pain effectiveness of bed color and size; (3.) Wound coccyx: apply Mepilex daily ed); and (4.) Wound care right bilex every 3 days and PRN					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00399	B. WING		06/29/2016	
IAME OF F	ROVIDER OR SUPPLIER	STREET #	ADDRESS, CITY, ST	TATE, ZIP CODE		
BENEDIC	TINE LIVING COMM		EIN STREET ER, MN 56082			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 9	2 900			
	dressing and or 4 > as needed.	4 Mepilex. Change daily and				
	History revealed th changed every thir redness to the bott Documentation in t indicate a nursing a conducted related	Treatment Administration e coccyx wound dressing was d day and monitoring of the om was initialed every shift. he record was lacking to assessment had been to the condition and he wound by facility and/or the aff.				
	the following: -6/15/16-Resident of being sore from he have to find the rig comfortable", call p bring a pressure re- tomorrow; -6/22/16- did clean apply new Mepilex is a stage 2-3. Mos yellow/green in colo odor. A second Me area which is stage -6/29/16-Wound ha dressing is remove with purulent draina measures 4.5 x 5 c at deepest point. W slough. Black necre edge at 7 o'clock. N 0.3 cm. Second wo	ing progress notes identified complained of her buttock r mattress. Resident states, "I ht groove to make it placed to hospice and they will educing mattress for her se the wound with saline and border on coccyx wound which is of the wound bed is or. Wound does have some pilex applied on right ischial e two; and as very foul smell when ed and old dressing saturated age. Wound on coccyx cm (centimeters) and is 0.3 cm /ound bed is 100% yellow otic tissue noted at wound Necrotic area measures 1 cm ound on left buttock below 2.8 x 2.5 cm. Wound bed is re	h			
		in surrounding wounds is red				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00200	B. WING				
		00399			06/	06/29/2016	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻ EIN STREET	TATE, ZIP CODE			
SENEDIC	CTINE LIVING COMM	LINITY	ER, MN 56082				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 900	Continued From pa	age 10	2 900				
	Mepilex dressing is evening and was la stated she had not and confirmed a way been completed sin after a review of the When interviewed of director of nursing contact with the ho stated the hospice believe that they [h and monitor pressu in the 4/29/16, hosp PU were reviewed following: (1.) Mon and integrity with e Assess wound loca skin, pain effective color and size. The interesting, she will she arrives." [Refe	RN)-A stated that R143's changed every 3 days in the ast changed on 6/27/16. RN-A recently viewed the wound bund assessment had not nee 5/11/16. RN-A verified this e electronic medical record. on 6/28/16, at 2:55 p.m. the (DON) stated she had been in spice provider. The DON nurse indicated she did not ospice] needed to measure ure ulcers. Interventions listed pice care plan related to the with the DON and included the itor skin for redness, warmth, ach skilled nurse visit; and (2. ation, drainage, surrounding ness of treatment, wound bed e DON replied, "that's want to talk with you when erencing the hospice nurse]. on 6/28/16, at 3:51 p.m. B confirmed that review of the itted assessment and PU ere was one entry on 6/8/16	9				
	and 6/22/15 by hos would review with t for assessment, me the pressure wound	pice nurse. RN-B stated she he hospice team the necessity onitoring, and intervention of	,				
	DON stated the fac rounded weekly. T nurse had not revie discovered. The Do the new PU when o	bility had a wound nurse that he DON confirmed the wound wed R143's PU when ON verified being notified of discovered though the t been communicated to the					

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00399	B. WING		06/29/2016	
	PROVIDER OR SUPPLIER	LINITY 1907 KLE	EIN STREET	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	STPETE ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	R, MN 56082 ID PREFIX TAG	2 PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 900	wound nurse. Subs became involved w of the PU on 6/29/1 SUGGESTED MET director of nursing the pressure ulcer could provide educ the importance of a pressure reducing develop a system fi that interventions a basis. The quality a committee could d ulcer interventions receiving the appro-	equently, the wound nurse it the treatment/assessment				
2 920	Subp. 6. Activities comprehensive res home must ensure B. a resident who activities of daily liv services to maintain and personal and c This MN Requirem by: Based on observat review the facility fa assistance with sha	is unable to carry out ing receives the necessary n good nutrition, grooming,	2 920	Acknowledged		7/21/16

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00399	B. WING			
IAME OF F	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, ST	TATE, ZIP CODE		
BENEDIC	CTINE LIVING COMM	IINITY	KLEIN STREET ETER, MN 56082			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	age 12	2 920			
	Findings included:					
	6/28/16 at 8:38 a.m R47 was observed facial hairs on her	is on 6/27/16 at 3:27 p.m., n. and 6/29/16 at 7:58 a.m., to have long thin black/gra chin and upper lip which mately 1/4 to 1 inch in lengt	y			
		er the care plan dated 4/22 weakness and blindness of				
	4/7/16, included a l Status (BIMS) scor moderate cognitive also indicated R47	nimum Data Set (MDS) data Brief Interview for Mental re of 9 out of 15, indicating impairment. The assessing required extensive physica off member for personal essing.	nent			
	self-care deficit in a grooming. The care assist resident with do not feel they ne	ted 4/22/16 included a areas of dressing, bathing, e plan revealed "Family will n shaving any facial hair, the ed to provide a electric raze t they will pluck any facial h	ey or			
	stated she used to herself when still a her now and her ch removed from her the same shirt on h is soiled with dried	on 6/29/16, at 7:58 a.m. R4 take care of the facial hair thome. R47 stated staff he noice would be to have the chin. R47 is observed to ha her that she had on 6/28/16 on food debris which is ront of her blouse from h.	elp hair ave			
	nurse manager (NI	on 6/29/16, at 8:49 a.m. the M)-B stated R47's daughter or R47's birthday two days	r			

STATEMEN	ta Department of H	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00399	B. WING		06/	29/2016
NAME OF F	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, S	TATE, ZIP CODE		
BENEDIC	TINE LIVING COMM					
	SUMMARY ST		TER, MN 56082	PROVIDER'S PLAN OF		(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	age 13	2 920			
	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.		to d,			
	trained medication encourage R47 to TMA-A stated staff completing simple and brushing teeth presence of the lor blouse. TMA-A sta the facial hair for F verified there was	on 6/29/16, at 9:12 a.m. aide (TMA)-A stated staff help participate with her care f need to assist R47 with tasks, such as combing hair h. TMA-A confirmed the ng facial hairs and the soiled ated staff are directed to leav R47's daughter to remove, ar not an available razor supplie esident use nor an alternate	re			
	director of nursing razor was not prov infection control pu family members ar	on 6/29/16, at 12:45 p.m. the (DON) confirmed a communided by the facility due to urposes. The DON stated re requested to provide razor pts had been made for R47's razor.	nity rs			
	director of nurses a pertinent policies a grooming, audit re- needs are met and importance of groo audit could be repo	THOD OF CORRECTION: T and/or designee could review and procedures related to sident care to ensure groom d educate staff on the oming needs. The results of t orted during the quarterly committee meetings.	v ing			
mocata D	(21) days.	R CORRECTION: Twenty-or	ne			
Inesota De	epartment of Health A		⁶⁸⁹⁹ 6	DLY11	If continuati	on sheet 14 o

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED
		00399	B. WING		06/	29/2016
NAME OF I	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE, ZIP CODE		
BENEDI	CTINE LIVING COMM		KLEIN STREET TER, MN 5608			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
f e F E r r r r r	A nursing home m functional, comforta environment, allow	0 Physical Environment ust provide a safe, clean, able, and homelike physical ing the resident to use is to the extent possible.	21665			7/21/16
	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		t	Acknowledged		
	light brown, sticky s the upper lip of the in the bottom of the brown food debris stove top. The floc black buildup in fro The cupboards sto	oven was observed to have substance with food debris of oven door, dried black debris oven and heavy soiling with underneath the burners on t or was noted to be sticky, with nt of the oven and dishwash ring cups and plates for observed to have soiled le surfaces.	on is n he th			
	Angel Wing pantry black buildup in fro with the sticky subs	on 6/28/16, at 9:24 a.m. the floor was observed again w nt of the dishwasher and ov stance on the oven door and e the oven still present.	ith en,			
	11:29 a.m. the dieta	and interview on 6/28/16, a ary manager (DM) indicated ntry was "absolutely not" clea				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00399	B. WING		06/	06/29/2016	
NAME OF I	PROVIDER OR SUPPLIEF	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
BENEDIO			EIN STREET				
0(0)15			R, MN 56082	PROVIDER'S PLAN OF			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE	
21665	Continued From p	age 15	21665				
		the dietary staff were aning the pantry and utilized s/procedures.					
	Procedures, last re culinary services a sanitation of the ne each meal period floors, refrigerators range and dish ma and mopped after	lealth System Pantry Cleaning evised 6/16 indicated the uides were responsible for the eighborhood pantries following including countertops, tables, s, stove/ovens, microwave achine. Floors are to be swept the lunch hour daily by culinary swept after the dinner hour by es aide.	,				
	director of nursing educate staff rega clean, functional a DON or designee, staff to conduct ro residents frequent functional and hon maintained to the	THOD OF CORRECTION: The (DON) or designee, could rding the importance of a safe, nd homelike environment. The could coordinate with dietary utine periodic audits of areas to ensure a safe, clean, nelike environment is extent possible. PR CORRECTION: Twenty-one					