

Protecting, maintaining and improving the health of all Minnesotans

Certified Mail # 7013 3020 0001 8869 0763

February 26, 2016

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

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

Dear Mr. Hoemberg:

This is in response to your letter of December 16, 2015, in regard to your request for an informal dispute resolution (IDR) for the federal deficiency issued at tag F314 S/S-G 483.25(c) issued pursuant to the survey event 60S711, completed on November 25, 2015.

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

F314 S/S-(G) 42 CFR § 483.25(c) : Pressure Sores-Based on the comprehensive assessment of a resident, the facility must ensure that (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

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

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

Benedictine Care Community February 26, 2016 Page 2

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

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

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

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

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

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

Sincerely,

Kakryn Serie

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

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

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

					AND TRANSMITTAL FE SURVEY AGENCY	ID: 60S7 Facility ID: 00413
1. MEDICARE/MEDICAID PROVIDER N           (L1)         245502           2.STATE VENDOR OR MEDICAID NO.         (L2)           (L2)         254740600           5. EFFECTIVE DATE CHANGE OF OWN		<ol> <li>NAME AND ADI (L3) BENEDICTI (L4) 201 9TH STF (L5) ADA, MN</li> <li>PROVIDER/SUF</li> </ol>	NE CARE COMM	IUNITY	(L6) <b>56510</b>	4. TYPE OF ACTION:       _7(L8)         1. Initial       2. Recertification         3. Termination       4. CHOW         5. Validation       6. Complaint         7. On-Site Visit       9. Other
(L9) <b>07/01/2008</b>		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 01/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	<b>26/2016</b> (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/30
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:			
From (a): To (b): 12.Total Facility Beds	<b>49</b> (L18)	X A. In Complian Program Re Compliance 1. A	quirements		And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF)	<ul> <li>6. Scope of Services Limit</li> <li>7. Medical Director</li> <li>8. Patient Room Size</li> </ul>
13.Total Certified Beds	<b>49</b> (L17)		pliance with Program ents and/or Applied W	aivers:	5. Life Safety Code * Code: A	9. Beds/Room (L12)
14. LTC CERTIFIED BED BREAKDOWN		I			15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARK	XS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AP	PROVAL Date:
Jana Bromenshenkel, HI	FE NE II		02/05/2016	(L19)	Kamala Fiske-Downing, I	Enforcement Specialist 02/05/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONA	L OFFICE OR SINGLE STAT	'E AGENCY
19. DETERMINATION OF ELIGIBILITY          1. Facility is Eligible to Par          2. Facility is not Eligible			PLIANCE WITH CI ITS ACT:	VIL	<ol> <li>Statement of Finance</li> <li>Ownership/Control</li> <li>Both of the Above :</li> </ol>	ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEMEN	NT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 11/01/1987	BEGINNING I	DATE	ENDING DATE		VOLUNTARY     00       01-Merger, Closure	0 INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination	nt 06-Fail to Meet Agreement
25. LTC EXTENSION DATE: (L27)	<ol> <li>ALTERNATIVE</li> <li>A. Suspension of</li> <li>B. Rescind Susp</li> </ol>	of Admissions:	(L44)		04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
		L	(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS	
		00320				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	DETERMINATION (	OF APPROVAL DAT	Е	Posted 01/11/2016 Co.	
	(L32)			(L33)	DETERMINATION APPRO	VAL



Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245502

February 5, 2016

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

Dear Mr. Hoemberg:

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 January 4, 2016 the above facility is certified for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kumalu 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



Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered February 5, 2016

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

RE: Project Number S5502026

Dear Mr. Hoemberg:

On December 10, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 25, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On January 26, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 25, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 4, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 25, 2015, effective January 4, 2016 and therefore remedies outlined in our letter to you dated December 10, 2015, will not be imposed.

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

Feel free to contact me if you have 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

# **POST-CERTIFICATION REVISIT REPORT**

	MULTIPLE CONSTRUCTION			DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building				
245502 <sub>Y1</sub>	B. Wing	Y	Y2	1/26/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
BENEDICTINE CARE COMMU	NITY	201 9TH STREET WEST			
		ADA, MN 56510			

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

ITEM	DATE	ITEM		DATE	ITEM			DATE
Y4	Y5	Y4		Y5	Y4			Y5
ID Prefix F0155	Correction	ID Prefix F0279	)	Correction	ID Prefix	F0282		Correction
Reg. #	Completed	Reg. #	0(d), 483.20(k)(1)	Completed	Reg. #	483.20(k)(3)(ii)		Completed
LSC	01/04/2016	LSC		01/04/2016	LSC			01/04/2016
ID Prefix F0309	Correction	ID Prefix F0312	2	Correction	ID Prefix	F0314		Correction
483.25 Reg. #	Completed	483.25 Reg. #	5(a)(3)	Completed	Reg. #	483.25(c)		Completed
LSC	01/04/2016	LSC		01/04/2016	LSC			01/04/2016
ID Prefix F0329	Correction	ID Prefix F0406	6	Correction	ID Prefix	F0428		Correction
483.25(l) Reg. #	Completed	483.45 Reg. #	5(a)	Completed	Reg. #	483.60(c)		Completed
LSC	01/04/2016	LSC		01/04/2016	LSC			01/04/2016
ID Prefix F0441	Correction	ID Prefix F0465		Correction	ID Prefix			Correction
483.65 Reg. #	Completed	Reg. #	J(II)	Completed	Reg. #			Completed
LSC	01/04/2016	LSC		01/04/2016	LSC			
ID Prefix	Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	Completed	Reg. #		Completed	Reg. #			Completed
LSC		LSC			LSC			
REVIEWED BY		DATE	SIGNATURE OF	SURVEYOR			DATE	
STATE AGENCY	I (INITIALS) LB/kfd	2/5/2016	3	2601			01/2	26/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOWUP TO SURV 11/25/2015	EY COMPLETED ON		R ANY UNCORREC					s 🗌 no



Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered

February 5, 2016

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

Re: Reinspection Results - Project Number S5502026

Dear Mr. Hoemberg:

On January 26, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 24, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

#### STATE FORM: REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF REVIS	SIT
	B. Wing		Y2	1/26/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
BENEDICTINE CARE COMMU	NITY	201 9TH STREET WEST			
		ADA, MN 56510			

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITE	Μ	DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	20560	Correction	ID Prefix	20565		Correction	ID Prefix	20830		Correction
Reg. #	MN Rule 4658.04 Subp. 2	405 Completed		MN Ru Subp. 3	e 4658.0405 3	Completed	Reg. #	MN Rule 4658.05 Subp. 1	20	Completed
LSC		01/04/2016	LSC			01/04/2016	LSC			01/04/2016
ID Prefix	20900	Correction	ID Prefix	20920		Correction	ID Prefix	21375		Correction
Reg. #	MN Rule 4658.09 Subp. 3	525 Completed		MN Ru Subp. 6	e 4658.0525 6 B	Completed	Reg. #	MN Rule 4658.08 Subp. 1	00	Completed
LSC		01/04/2016	LSC			01/04/2016	LSC			01/04/2016
ID Prefix	21510	Correction	ID Prefix	21530		Correction	ID Prefix	21535		Correction
Reg. #	MN Rule 4658.12 Subp. 2 A.B.	200 Completed		MN Ru A.B.C	e 4658.1310	Completed	Reg. #	MN Rule4658.131 Subp.1 ABCD	15	Completed
LSC		01/04/2016	LSC			01/04/2016	LSC			01/04/2016
ID Prefix	21695	Correction	ID Prefix	21840		Correction	ID Prefix			Correction
Reg. #	MN Rule 4658.14 Subp. 4	415 Completed		MN St. Subd. 1	Statute 144.651 2	Completed	Reg. #			Completed
LSC		01/04/2016	LSC			01/04/2016	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC				LSC			
REVIEWI STATE A		REVIEWED BY (INITIALS)	DATE		SIGNATURE OF				DATE	/2016
REVIEWI CMS RO		<u>LB/kfd</u> REVIEWED BY (INITIALS)	2/5/2 DATE	2016	TITLE	32601			01/26 DATE	/2010
		COMPLETED ON			ANY UNCORRECTED DEFICIENCI					5 🗌 NO

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

					ND TRANSMITTAL	ID: 6	6OS7
	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AGENCY	Facili	ity ID: 00413
1. MEDICARE/MEDICAID PROVIDER N (L1) 245502	NO.	3. NAME AND ADI (L3) <b>BENEDICTI</b>				<ol> <li>TYPE OF ACTION:</li> <li>Initial</li> </ol>	<u>2 (</u> L8) 2. Recertification
2.STATE VENDOR OR MEDICAID NO. (L2) 254740600		(L4) 201 9TH STR (L5) ADA, MN	EET WEST		(L6) <b>56510</b>	5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9) 07/01/2008	NERSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Comple	9. Other aint
6. DATE OF SURVEY 11/25	<b>5/2015</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		TE (1.25)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DAT	TE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	06/30	
11. LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:				
From (a):		A. In Complian	ce With		And/Or Approved Waivers Of The	e Following Requirements:	_
To (b):		Program Re			2. Technical Personnel	6. Scope of Services I	Limit
12. Total Facility Beds	<b>49</b> (L18)	Compliance	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code	<ul> <li>7. Medical Director</li> <li>8. Patient Room Size</li> <li>9. Beds/Room</li> </ul>	
13. Total Certified Beds	<b>49</b> (L17)		pliance with Program nts and/or Applied V		* Code: <b>B</b> *	(L12)	
14. LTC CERTIFIED BED BREAKDOWN	1				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
49							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AP		Date:
Rebecca Haberle, H	FE NEII	1	12/21/2015	(L19)	Mark Meath	, Enforcement Specialis	t 01/08/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAI	OFFICE OR SINGLE STAT	<b>TE AGENCY</b>	
19. DETERMINATION OF ELIGIBILIT     1. Facility is Eligible to Pa			PLIANCE WITH CI ITS ACT:	IVIL	<ol> <li>1. Statement of Financ</li> <li>2. Ownership/Control</li> <li>3. Both of the Above :</li> </ol>	ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-15	13)
2. Facility is not Eligible	(L21)						
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	4. LTC AGREEME	NT	26. TERMINATION ACTION:	(L30)	)
OF PARTICIPATION	BEGINNING I	DATE	ENDING DATE	3	VOLUNTARY 00	INVOLUNTARY	<u>Y</u>
11/01/1987					01-Merger, Closure	05-Fail to Meet H	Iealth/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	nt 06-Fail to Meet A	Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVI	E SANCTIONS			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	
	A. Suspension of	of Admissions:	<b>7</b> 4 0		04-Other Reason for withdrawar	07-Provider State 00-Active	us Change
(L27)	B. Rescind Sus	pension Date:	(L44)			00-Active	
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS		
		00320					
				(7.8.4)	1		
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539		DETERMINATION C	DF APPROVAL DAT		Posted 01/11/2016 Co.		



Electronically delivered

December 10, 2015

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

RE: Project Number S5502026

Dear Mr. Hoemberg:

On November 25, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

<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:

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104 Fax: (218) 308-2122

## **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 4, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 4, 2016 the following remedy will be imposed:

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

## **ELECTRONIC PLAN OF CORRECTION (ePoC)**

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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.

Benedictine Care Community December 10, 2015 Page 4

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 February 25, 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

Benedictine Care Community December 10, 2015 Page 5

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 May 25, 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 related to this eNotice.

## Sincerely,

# Mark "meath

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO	. 0938-0391
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245502	B. WING			11/	25/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
BENEDIC	CTINE CARE COMMU	ΝΙΤΥ			01 9TH STREET WEST \DA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	FO	000			
F 155 SS=D	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of your validate that substar regulations has been your verification. 483.10(b)(4) RIGHT ADVANCE DIRECT The resident has the refuse to participate and to formulate an specified in paragra The facility must conspecified in subpart related to maintaini procedures regardi requirements include provide written infor concerning the righ or surgical treatment option, formulate an includes a written d	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with T TO REFUSE; FORMULATE TIVES are right to refuse treatment, to e in experimental research, a dvance directive as aph (8) of this section. To part 489 of this chapter ng written policies and ng advance directives. These de provisions to inform and rmation to all adult residents t to accept or refuse medical nt and, at the individual's n advance directive. This lescription of the facility's nt advance directives and	F 1	155			1/4/16
		DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE
Electron	ically Signed						12/18/2015

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.

	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	SURVEY PLETED
		245502	B. WING _		11/2	25/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	ΝΙΤΥ		201 9TH STREET WEST ADA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' 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) COMPLETION DATE
F 155	Continued From pa	ge 1	F 15	5		
	by: Based on observat review the facility fa risk for pressure uld related to the risk v repositioning assist observed with a cur refused repositionin Findings include: R5's quarterly Minir 8/23/15, indicated F diabetes, history of the development of also indicated R5 h extensive assistance and was unable to a R5's Pressure Ulce (CAA) dated 2/20/1 the development of for assistance with of incontinence. Th a history of periphe neuropathy in his lo assessment directed redistribution cushid utilize specialized b R5's care plan date ensure R5 utilized a	num Data Set (MDS) dated R5 was diagnosed with a stroke and was at risk for pressure ulcers. The MDS ad intact cognition, required a with bed mobility, transfers ambulate. r Care Area Assessment 5, indicated R5 was at risk for pressure ulcers due to need mobility, transfers and history be CAA also indicated R5 had ral artery disease, edema and over extremities. The ed staff to utilize a pressure on on his wheelchair and to		R5 will receive education that is producumented of risk vs. benefit educts on he has full scope of what can had he is not properly repositioned. All residents that refuse scheduled repositioning will receive education properly documented of risk vs. bere being properly positioned. DON/des will ensure that CNA staff will inform Charge Nurse of residents that are refusing proper cares. Charge Nurse enter a progress note of refusal of that any further residents that refuse will receive education of risk vs. bere to follow proper plan of care. Care will be adjusted as changes are man Staff will be educated at monthly state meeting on 12-16-15. DON/designed perform daily audits of progress note CNA repositioning log/toileting log to ensure that resident is that refuse procare are passed onto DON/designed educate them. Audits will be review Quality Council on 01/20/16.	that is ppen if that is nefit of signee n se will care so e care nefits plans de. aff se will tes and o olan of se to	

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		AND HUMAN SERVICES				FORM	12/22/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245502	B. WING			11/2	25/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	NITY			01 9TH STREET WEST \DA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 155	the left foot when in Holister heel, lift bo foot in bed and a Pr when in the wheeld staff to assist R5 to R5's Braden Scale pressure ulcer risk) was at moderate ris pressure ulcer. R5's Progress Note had developed a pa scab/dead tissue) of measured 2.1 centi R5's Progress Note wound was still press On 11/24/15, at 7:1 dining room, seated R5 was continuous until 10:30 a.m. -At 7:31 a.m. R5 wh his room where he -At 8:20 a.m. nursin reposition R5 but he -At 9:52 a.m. NA-D refused assistance. -At 9:50 a.m. NA-E assistance during th allowed the day shift had arrived at the fa -At 10:00 a.m. NA-F	<ul> <li>a bed. R5 was to utilize a ot (formed boot) on the right revalon boot on the right foot hair. The care plan directed reposition every two hours.</li> <li>(tool utilized to identify dated 11/17/15, indicated R5 sk for the development of sk for the development of black eschar (thick on his left heel which imeters (cm) by 1.5 cm.</li> <li>a dated 11/21/15, indicated the sent on R5's left heel.</li> <li>5 a.m. R5 was observed in the d in a wheelchair. Iy observed from 7:30 a.m.</li> <li>b heeled from the dining room to turned on the television. In assistant (NA)-D offered to e refused.</li> <li>c stated R5 frequently refused he day. She stated R5 had not ft staff to assist him since they</li> </ul>		155			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	12/22/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245502	B. WING			11/2	25/2015
NAME OF	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	INITY			D1 9TH STREET WEST DA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 155	time. She stated the into the wheelchair not accepted assist that time. -At 10:15 a.m. R5 w with a ceiling lift (fu ceiling) from the wheelchair was observed pressure redistribut was observed pink were observed to b Prevalon boots. N/ the wheelchair for g minutes and had re- repositioning. Review of R5's clin documentation indi- repositioning / refus relationship to press On 11/24/15, at 12: (RN)-A stated R5's area of concern on was soft and had a it was intact. She s Hollister boots were boots were implem a long history of ref- members and she fi about refusals but fi identified concern. On 11/24/15, at 3:4	The night staff had assisted R5 before 6:00 a.m. and he had tance with repositioning since was observed to be transferred all body lift attached to the neelchair to the toilet. R5's served equipped with a tion cushion. R5's buttocks with the skin intact. R5's feet be covered with bilateral A-D confirmed R5 had been in greater than 4 hours and 15 efused assistance with attor repositioned in soure ulcer prevention. A0 a.m. registered nurse left heel was noted to have an 10/27/15. She stated the heel in area of 1.8 cm x 2.1 cm but stated at that time, R5's e removed and the Prevalon ented. She explained R5 had fusing care from staff had talked to him the past had not documented the	F 1	55			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245502	B. WING _			11/2	25/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	CTINE CARE COMMU	NITY		-	11 9TH STREET WEST DA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' 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) COMPLETION DATE
F 155	Continued From pa documented those	ge 4 concerns in the clinical record.	F 15	55			
	recall any staff men	0 p.m. R5 stated he could not nbers talking to him about the sitioning or pressure ulcer					
	Prevalon boot and o was observed to ha tissue loss in which completely obscure	5 a.m. RN-A removed R5's left dressing from the left heel. R5 we a stage four (full thickness actual depth of the ulcer is d by eschar (black) in the area on the left heel which by 1.3 cm.					
F 279 SS=D	indicated any time a the staff were to do how the resident wa the treatment and the receiving the treatment refusals and alternation		F 27	79			1/4/16
		he results of the assessment and revise the resident's n of care.					
	plan for each reside objectives and time medical, nursing, and	evelop a comprehensive care ent that includes measurable tables to meet a resident's nd mental and psychosocial tified in the comprehensive					

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		AND HUMAN SERVICES			F	ORM A	12/22/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X		SURVEY
		245502	B. WING			11/2	5/2015
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	CTINE CARE COMMU	INITY			01 9TH STREET WEST DA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279	Continued From pa assessment.	ige 5	F 2	279			
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident' §483.10, including under §483.10(b)(4	, 					
	by: Based on interview facility failed to dev behavior care plan behaviors and nong for 1 of 1 resident needed (PRN) anti- Findings include: R49's care plan ide area for psychotrop interventions direct effects of the psych physician and phan per guidelines for g care plan lacked ide for the use of the P nonpharmacologica	al interventions to be he administration of the			Target Behaviors and non-pharmacological interventions specific to the resident have been add to R49 care plan to alert med nurse w it is appropriate to give a PRN psychotropic medication. A review of residents will be conducted and completed identifying all residents that have a PRN psychotropic medication those that have a behavior section of care plan. Targeted behaviors will be added to the psychotropic section of t care plan and the behavior & mood sections of the care plan will be review and edited to ensure resident specific non-pharmacological interventions an place and available for staff to use. So was educated on December 16th 201 the staff meeting on where to find res specific targeted behaviors and non-pharmacological interventions to prior to administrating a medication.	vhen all at and the the wed c re in taff I5 at sident try	

Facility ID: 00413

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TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DAT	<u>. 0938-03</u> E SURVEY IPLETED
ND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		CON	/IPLETED
		245502	B. WING _			11/	25/2015
IAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	TINE CARE COMMU	NITY			01 9TH STREET WEST DA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 279	R49's Physician Or 10/25/15-11/25/15, that included chron disease, anxiety dis dementia. In additi had ordered loraze could be given PRN generalized anxiety identified specific ta the PRN lorazepam R49's PRN Medica dated 9/1/15 - 11/29 received lorazepam 9/24/15, 10/5/15, 10 lorazepam 0.5 mg I variety of reasons a self-transferring, re R49's medical reco regards to nonphar attempted prior to t lorazepam on 9/13/ On 11/24/15, at 3:4 (RN)-B confirmed t nonpharmacologica specifically identifie for the utilization of RN-B stated the licr usually developed t care plan which wo	der Report dated indicated R49 had diagnoses ic obstructive pulmonary sorder, heart failure and on, on 8/18/15, the physician pam 0.5 milligrams (mg) that V up to three times a day for V. However, the order had not arget behaviors for the use of	F 2	79	listed in the psychotropic section care plan, if non pharmaceutical interventions are listed under the plan addressing the behavior and psychotropic review team will mea monthly to review care plans for F psychotropic medication to ensure compliance. Audits will be brough Quality Council on 1/20/16.	care the et PRN	
	target behaviors an	0 a.m. LSW-A confirmed d nonpharmacological ot been specifically identified					

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		AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245502	B. WING _		11/:	25/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	ΝΙΤΥ		201 9TH STREET WEST ADA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST 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) COMPLETION DATE
F 279		ge 7 for the PRN use of the	F 27	79		
F 282 SS=D	would have a comp included measurabl resident's medical, needs. The care pl services that would s highest practicabl psychosocial well-b maintained. 483.20(k)(3)(ii) SEF PERSONS/PER CA		F 28	82		1/4/16
	must be provided b	led or arranged by the facility y qualified persons in Ich resident's written plan of				
	by: Based on observat review, the facility fa turning and repositi by the care plan for identified at risk for failed to provide inc by the care plan for required assistance failed to provide ora (R15) observed who	NT is not met as evidenced tion, interview and document ailed to provide every two hour oning assistance as directed 1 of 3 residents (R13) pressure ulcers. The facility continence cares as directed 1 of 3 residents (R3) who with incontinence cares and al cares for 1 of 2 residents o required oral care ted by the care plan.		R13 will receive timely turning an repositioning. R3 will receive time incontinence cares and R15 will r oral care per the resident plan of DON/designee will ensure that all residents receive turning and repositioning, incontinent care an care per their plan of care by aud these daily. Staff will receive just training up to disciplinary action if of care is not being followed. Sta educated at the monthly staff me 12/16/15. Audits will be reviewed Quality Council on 1/20/16.	ly ecceive care. d oral ting n time the plan ff will be eting on	

Facility ID: 00413

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245502	B. WING			11/3	25/2015
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		10/2010
BENEDIC	CTINE CARE COMMU	NITY			01 9TH STREET WEST		
				A	NDA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 8	F 28	82			
		ided every two hour ance as directed by the care					
	integrity as a proble apply foam boots or reposition R13 ever	ted 9/2/15, identified skin em area and directed staff to n both feet when in bed, ry two hours, observe skin and bathing and report any areas.					
	(NA)-B was observe proceed to assist R had a blue foam bo calf elevated on a p morning cares by w hands upon instruct changed R13's inco was observed to ha ulcers, one on the le the bony prominence applied a thin layer to R13's bottom and -At 8:15 a.m. NA-B to R13's wheelchair relieving cushion in -At 8:38 a.m. NA-B common area and p near the fire place. his right foot. -At 9:10 a.m. R13 c trained medication a another blanket and	3 a.m. nursing assistant ed to enter R13's room and 13 with morning cares. R13 ot on his left foot with his right billow. R13 participated in his vashing his own face and tion by NA-B. When NA-B bontinent brief, R13's buttocks two two stage II pressure eft and one on the right over ces of his buttocks. NA-A of ointment and barrier spray d applied a clean brief. transferred R13 from the bed r which had a pressure its seat. transported R13 out into the positioned R13's wheelchair R13 had a blue foam boot on complained of being cold and aide (TMA)-B retrieved d placed over R13's shoulders. ed in his wheelchair in the					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	12/22/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245502	B. WING			11/2	25/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	INITY			01 9TH STREET WEST ADA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	common area, until transported R13 ba -At 10:13 a.m. TMA registered nurse (R change to R13's rig seated in the wheel change. - At 10:40 a.m. (two R13 had last been RN-B transferred R to R13's bed. RN-E confirmed R13 had buttocks and R13's TMA-B retrieved a measured both ope pressure ulcer on th length x 0.6 cm in v the left measured 0 confirmed both of th new. On 11/24/15, at 1:5 of nursing (DON) co expectation for staf regards to R13's ev repositioning sched prevention interven On 11/24/15, at 9:0 should be reposition	<ul> <li>I 10:10 a.m. when TMA-B ack to his room.</li> <li>A-B with the assistance of RN)-B completed a dressing ght lower leg. R13 remained lchair during the dressing</li> <li>b hours and 25 minutes since repositioned) TMA-B and R13 from the wheelchair back B removed R13's dry brief and I two open areas on his a bottom was reddened.</li> <li>measuring tape and RN-B en areas. RN-B verified the he right side was 0.7 cm in width and the pressure ulcer on 0.7 cm x 0.8 cm. RN-B hese pressure ulcers where</li> <li>60 p.m. RN-B and the director onfirmed it was their ff to follow R13's care plan with very two hours turning and dule and other pressure ulcer</li> </ul>	F 2	282			

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		AND HUMAN SERVICES				FORM	12/22/2015 APPROVED
	<u>RS FOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MU		E CONSTRUCTION		0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		045500					
		245502	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	11/2	25/2015
	PROVIDER OR SUPPLIER				01 9TH STREET WEST		
BENEDIC	CTINE CARE COMMU	NITY			NDA, MN 56510		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETION DATE
		· · ·			DEFICIENCY)		
F 000							
F 282	Continued From pa	.ge 10	F 2	282			
	R3's was not provid	ded incontinence cares every					
		ed by the care plan.					
		-					
	B3's care plan iden	tified on 2/11/15, a problem					
	area for bowel statu	us. The interventions directed					
		ery night before bed, provide					
		th managing incontinence and e a day and after each					
		e. In addition, R3's care plan					
	identified on 7/28/1	5, a problem area for urinary					
		staff to provide extensive ence episodes and to check					
		incontinent product every two					
	hours.	, , , , , , , , , , , , , , , , , , ,					
	On 11/24/15, R3 wa	as continuously observed from					
	7:10 a.m. until 10:1	3 a.m. (three hours and three					
		is time, R3 remained in her					
	assistance.	ack without personal care					
		y assistant (DA)-A entered					
		ed a breakfast tray on the					
		raised the head of the bed. Ig R3 toileting assistance.					
		C knocked on the door, walked					
	into room and took	the breakfast tray from in front					
		d a bed bath on R3, then					
	movement and urin	vhich was full of bowel ne.					
	Op 11/04/15 at 1.5	0 n m DN B and the DON					
		0 p.m. RN-B and the DON eir expectation for staff to					
		an with regards to R3 being					
		ged every two hours as					
	directed by R3's ca	re plan.					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	X3) DATE SURVEY			
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING .		COM	PLETED		
		245502	B. WING			11/2	25/2015		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 01 9TH STREET WEST				
BENEDIC	ENEDICTINE CARE COMMUNITY			ADA, MN 56510					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 282	Continued From pa	ge 11	F 2	82					
		06 a.m. trained medication stated R3 should be checked two hours.							
	R15's was not provi the care plan.	ided oral cares as directed by							
	a deficit with self-ca of daily living (ADL's assist with personal	ed 9/16/15, identified R15 had are performance with activities s) and required extensive I hygiene cares and directed ath cares due to Gouty tophi ) on R15's hands.							
	enter R15's room at personal cares. NA in her bed, provide NA-A utilized an ove her wheelchair. NA- opened a denture d plate into her mouth dry with a thin line of of her mouth. Durin not offered or assis -from 7:53 a.m. to 9 consume breakfast common activity are tables. R15 was not care.	8 a.m. NA-A was observed to nd proceed to complete R15's -A was observed to bathe R15 personal cares and dress her. er-head lift to transfer R15 to -A combed her hair and then lish and inserted R15's top n. R15's lips were observed of white matter at the corners g this observation R15 was ted with oral cares. 0:50 a.m. R15 was observed to and was assisted to the ea and situated at one of the t offered or assisted with oral							
		al cares before or after							

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		AND HUMAN SERVICES			FORM	12/22/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		245502	B. WING		11/2	25/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIO	CTINE CARE COMMU	INITY		201 9TH STREET WEST ADA, MN 56510		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	breakfast. NA-A sta	ated she usually used swabs clean R15's mouth and she	F 282	2		
		7 p.m. RN-A stated R15 provided oral cares as directed				
	should have been p	D p.m. the DON stated R15 provided or offered oral cares es. The DON confirmed R15's ollowed.				
	indicated each resident to incorporate ident appropriate profess each element of ca interventions where	are Plans policy dated 10/10, dent's care plan was designed tified problem areas and the sional services responsible for tre. In addition, care plan to be designed to address trees of the problem areas				
F 309 SS=D	residents would have which described the furnished to the respracticable physical well-being would be 483.25 PROVIDE (HIGHEST WELL B) Each resident must provide the necess	undated) indicated all ve a comprehensive care plan e services which were to be sident so the resident's highest il, mental and psychosocial e attained and maintained. CARE/SERVICES FOR EING t receive and the facility must ary care and services to attain hest practicable physical,	F 309			1/4/16

Facility ID: 00413

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	12/22/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (		E SURVEY PLETED
		245502	B. WING			11/2	25/2015
NAME OF	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	INITY	201 9TH STREET WEST ADA, MN 56510				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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 309	mental, and psycho accordance with th and plan of care. This REQUIREMED by: Based on observa review, the facility f of a wound cleansin after staff had repla product's container the potential to affe who currently had w treatments. Findings include: R13's Physician Or 11/25/15, identified chronic non-pressu R13's dressing to th on the right calf wat a day. On 11/24/15, at 100 aide (TMA)-B comp R13's right calf wot and transported R1 his hands in the ba of gloves. R13 rem beside his bed. TM floor facing R13. T from R13's right leg nurse (RN)-B enter	Age 13 Desocial well-being, in e comprehensive assessment NT is not met as evidenced tion, interview and document ailed to ensure proper labeling ng product was maintained aced the contents of the with sterile water. This had ect residents (R5, R13, R38) wounds which required routine re ulcer to his calf. In addition, his non-pressure related ulcer s ordered to be changed twice to be changed twice and the communication beted a dressing change on und. TMA-B gathered supplies 3 to his room. TMA-B washed throom sink and donned a pair nained seated in his wheelchair MA-B situated himself on the MA-B removed the foam boot g. At 10:13 a.m. registered red R13's room to assist dressing change. TMA-B	F 3	809	R5, R13 and R38 will have the prop labeled wound cleanser in the prope bottles for their wound treatments. A residents with wound cares will have proper labeled bottles used for their dressing treatments. Other substan- will not be poured from one bottle in another. DON/designee will educate on 12/16/2015 at staff meeting on no replacing the contents of the product bottle with anything other than what it he label. DON/designee will audit treatment supplies weekly to be sure the proper cleansers are being used dressing treatments, documented ar brought to Quality Council Meeting b 01/20/16.	er III e the ces to e staff ot t in a is on e that I for nd	

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 12/22/2015 APPROVED : 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION G	(X3) DATI	E SURVEY IPLETED
		245502	B. WING	<u></u> ډ		11/:	25/2015
NAME OF	PROVIDER OR SUPPLIER		<u></u>		STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	INITY			201 9TH STREET WEST ADA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	removed the dried I R13's right leg. TW cleanser (a first aid active ingredient of 0.13%) on the wour inch by 4 inch (4 x 4 wound. TMA-B ran cleanser spray. RN retrieved a bottle of the sterile water inte "dermal wound cleas spray the sterile water removed the remain and placed them in right lateral lower let to be down to the b bloody with copious (yellowish drainage that had went throu ABD dressing (a ste dressing) and the s wound had measur length by 5.5 cm wi opened and placed 4 gauze dressing s wound. TMA-B pla 4 x 4 gauze dressing the bin of supplies of bottle labeled derm which contained ste medication drawer others to use.	age 14 bloody stained stockinet from MA-B sprayed dermal wound antiseptic spray with the Benzethonium chloride nd and removed the adhered 4 4) gauze dressings from the n out of the dermal wound I-B left R13's room and f sterile water. RN-B poured o the spray bottled labeled anser." TMA-B continued to ater onto R13's wound and ning 4 x 4 gauze dressings a nearby garbage. R13's eg stasis ulcer was visualized oone; wound appeared raw and s amounts of serosanguineous e with small amounts of blood) agh the 4 x 4 gauze dressings, erile highly absorbent stockinet. On 11/20/15, this red 23.5 centimeters (cm) in ide and 2.0 cm deep. TMA-B I three sterile packages of 4 x and applied them to R13's uced an ABD dressing over the ngs. While RN-B held the ABD TMA-B placed a new stockinet d dressings. TMA-B removed I up the supplies and washed throom sink. TMA-B brought (which included the spray al wound cleanser, however erile water) back to the at the nursing station for	F	309			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245502	B. WING _			11/2	25/2015
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	CTINE CARE COMMU	NITY		201 9TH STREET WEST ADA, MN 56510			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' 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) COMPLETION DATE
F 309	Continued From pa spray bottled labele still contained sterile	d "dermal wound cleanser"	F 3	809			
	water had been poulabeled "dermal wor container had not b RN-B and the direct confirmed this was	6 p.m. RN-B verified sterile ured into the spray bottled und cleanser" and this een tossed or relabeled. tor of nursing (DON) not the facility's policy to do hould have been tossed.					
F 312 SS=D	replacing the conten- another solution wa 483.25(a)(3) ADL C DEPENDENT RES	ARE PROVIDED FOR IDENTS	F 3	12			1/4/16
	daily living receives	hable to carry out activities of the necessary services to tion, grooming, and personal					
	by: Based on observat review, the facility fa assistance with bow cares for 1 of 3 resi incontinence care. provide oral cares for required assistance	NT is not met as evidenced ion, interview and document ailed to provide timely vel and bladder incontinence dents (R3) reviewed for In addition, the facility failed to or 1 of 2 residents (R15) who e with oral cares.		ii c r a c c t	R15 will receive oral care twice dai her plan of care. R3 will receive tim incontinent care according to her pl care. DON/designee will ensure tha residents receive timely incontinent and oral care by daily auditing of bo Staff will receive just in time training disciplinary action if the plan of care being followed. All residents will be	ely an of t all care th. g up to e is not	
	Findings include:				assessed by DON/designee to ensu		

Event ID:60S711

Facility ID: 00413

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		AND HUMAN SERVICES				FORM	12/22/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245502	B. WING			11/25/2015	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	_	
BENEDIO	CTINE CARE COMMU	NITY			01 9TH STREET WEST \DA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From pa	ige 16	F3	312	that they have appropriate incontine	ent and	
	R3 was not provide hours on the morni	d incontinence care for over 3 ng of 11/24/15.			oral cares in place in their plan of c Staff will be educated on 12/16/15 a monthly staff meeting. Audits will be reviewed at Quality Council on 1/20	are. at e	
	8/28/15, indicated F impairment, was fre and bladder, had lin lower extremities bi extensive assistant transferring, toiletin Activity of Daily Livi Assessment (CAA) was frequently inco extensive assistant	num Data Set (MDS) dated R3 had moderate cognitive equently incontinent of bowel nited range of motion in the ilaterally and required ce with bed mobility, g and personal hygiene. R3's ng (ADL) Care Area dated 3/4/15, indicated R3 ntinent of urine, required ce with toileting and was on an eting program throughout the					
	area for bowel statu R3 every night befor assist with managir cares twice a day a episode. In addition 7/28/15, a problem directed staff to pro- incontinence episod	tified on 2/11/15, a problem us and directed staff to toilet ore bed, provide extensive ng incontinence and perineal and after each incontinence n, R3's care plan identified on area for urinary status and ovide extensive assist with des and to check and change rief every two hours.					
	indicated R13 was bladder and that sir toilet most of the tir	sment dated 8/25/15, frequently incontinent of nce R13 refused to use the ne she had been switched to a schedule throughout the day.					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 12/22/2015 M APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIF	PLE CONSTRUCTION	(X3) DA	D. 0938-0391
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DINC	G	CC	OMPLETED
		245502	B. WING			1	1/25/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST		
BENEDIO	CTINE CARE COMMU	NITY			ADA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 312	Continued From pa	ge 17	F	312	2		
	R13 was frequently	nent dated 8/25/15, indicated incontinent of bowel and that nged to a check and change ule.					
	11/25/15, indicated	ission Record printed on R3's diagnoses to include ssion, dysuria (painful or nd constipation.					
	7:10 a.m. until 10:1 minutes). During th room lying on her b -At 7:21 a.m. dietar R3's room and plac over bed table and DA-A lacked offerin -At 10:13 a.m. nurs on R3's door, walke breakfast tray from proceeded to start I	y assistant (DA)-A entered ed a breakfast tray on the raised the head of the bed. g R3 toileting assistance. ing assistant (NA)-C knocked ed into room and took the in front of R3. NA-C R3's bath. when NA-C opened ef, the brief was full of bowel					
		50 a.m. NA-C stated R3 was incontinent brief changed and very three hours.					
	(RN)-B and the dire confirmed it was the follow R3's care pla	0 p.m. registered nurse ector of nursing (DON) eir expectation for staff to in with regards to R3 being jed every two hours.					

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DEPART CENTE	FORM	APPROVED 0938-0391									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		245502	B. WING			11/25/2015					
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE	•					
BENEDIO	CTINE CARE COMMU	ΝΙΤΥ		201 9TH STREET WEST ADA, MN 56510							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE				
F 312	Continued From page 18		F3	312							
		06 a.m. trained medication stated R3 should be checked two hours.									
	No policy related to checking and chang	incontinence care specific for ging was provided.									
	R15 was not provid care plan.	ed oral care as directed by the									
	8/28/15, identified F and diabetes. The I moderate cognitive	imum Data Set (MDS) dated R15's diagnoses as depression MDS also indicated R15 had impairment and required h personal hygiene cares.									
	a deficit with self-ca and required extens hygiene cares and	ed 9/16/15, identified R15 had are performance with ADL's sive assist with personal directed staff to provide mouth tophi (gout complications) on									
	enter R15's room a personal cares. NA in her bed, provide NA-A utilized an ove her wheelchair. NA a denture dish and her mouth. R15's lip	8 a.m. NA-A was observed to nd proceed to complete R15's -A was observed to bathe R15 personal cares and dress her. er-head lift to transfer R15 to -A combed R15's hair, opened inserted R15's top plate into os were observed dry with a atter at the corners of her									

Facility ID: 00413

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	FORM	APPROVED									
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA         (X2) MULTIPLE CONSTRUCTION							MB NO. 0938-0391				
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED						
		245502	B. WING	_		11/	25/2015				
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE							
BENEDI	CTINE CARE COMMU	NITY		201 9TH STREET WEST ADA, MN 56510							
(X4) ID	SUMMARY STA		ID		PROVIDER'S PLAN OF CORRECTI		(X5)				
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETION DATE				
			ľ								
F 312	Continued From pa	ge 19	F 3	312							
		time R15 was not offered or									
	assisted with oral ca	ares.									
		7:53 a.m. to 9:50 a.m. R15									
		t and finish her breakfast									
		eakfast, R15 was assisted to y area and situated at one of									
	the tables. During the	his time, R15 was not offered									
	or assisted with ora	l care.									
	On 11/24/15, at 1:5										
	not provide oral cares to R15 during morning cares or following the breakfast meal. NA-A										
		utilized swabs and mouthwash									
	to clean R15's mouth and she should have done										
	that.										
		7 p.m. RN-A stated R15's oral									
		been provided as R15 was on									
	oxygen and her mo	util got dry.									
		) p.m. the DON confirmed R15 been offered mouth care									
	during morning care										
	g										
	The facility Oral by	aiono poliov (undeted)									
		giene policy (undated) aff would provide all residents									
	with mouth care eve	ery morning, night and as									
	needed.										
		undated) indicated all									
		ve a comprehensive care plan e services which were to be									

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	I	OM	<u>B NO. 0938-039</u>		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	(X3) DATE SURVEY COMPLETED 11/25/2015				
245502					B. WING		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
BENEDICTINE CARE COMMUNITY				201 9TH STREET WEST ADA, MN 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
F 312	Continued From page 20 furnished to the resident so the resident's highest practicable physical, mental and psychosocial well-being would be attained and maintained.		F 312	2			
F 314 SS=G	483.25(c) TREATM PREVENT/HEAL P	IENT/SVCS TO PRESSURE SORES	F 314	ŀ	1/4/16		
	resident, the facility who enters the faci does not develop p individual's clinical they were unavoida pressure sores rec	prehensive assessment of a r must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and e healing, prevent infection and from developing.					
	by: Based on observa review, the facility f implement appropr who developed two ulcers for 1 of 3 res	NT is not met as evidenced tion, interview and document ailed to identify, assess and iate interventions for a resident stage II pressure related sidents (R13) who developed re ulcers at the facility. This arm for R13.		R13 was placed on Q1HR reposition on 11/24/15 after RN was made awa pressure ulcers. R13 s pressure ulc were healed by 12/15/15, evidenced the skin team evaluation and residen passed away on 12/16/15. Resident already on a nutritional supplement, pressure reduction mattress, #3 crea	re of ers by t was ums		
	(MDS) dated 8/24/ <sup>-</sup> cognitive impairme	nange Minimum Data Set 15, indicated R13 had severe nt, was frequently incontinent er, required extensive assist		BID and with cares. All residents skir assessed weekly with bath and daily cares. Nursing staff will be educated 12/16/15 at our staff meeting on report any open area to Charge Nurse. Cha Nurse will then open an event and put progress note in Matrix. DON/design will review progress notes daily for an change in residents skin condition ar make sure events for all skin impairn	with l on arge ut in nee ny nd		

Facility ID: 00413

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		E & MEDICAID SERVICES		ייסו		MB NO.		
		A. BUILDI		(X3) DATE SURVEY COMPLETED				
		B. WING _			11/25/2015			
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BENEDICTINE CARE COMMUNITY					D1 9TH STREET WEST DA, MN 56510			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE	
F 314	personal hygiene. as being at risk for had existing venou than one pressure pressure reducing turning and reposit ulcer care.	In addition, R13 was identified pressure ulcer development, is and arterial ulcers and more ulcer. Skin treatment included device in R13's chair and bed, ioning program and pressure	F 3	14	interventions as needed, along with communicating those changes with Wound rounds are also completed with DON/designee and discussed Inter-disciplinary Team weekly. Aud be reviewed at Quality Council on T	n staff. weekly at dits will		
	8/26/15, indicated impairment and ha ulcers noted. Fact included provide as mobility, skin treatr integrity and report open areas to the o relieving devices in encourage/remind	ssessment (CAA) dated R13 was at risk for skin d pressure ulcers and stasis ors for R13's care plan ssistance with cares and bed ments as ordered, monitor skin any reddened, irritated or charge nurse, pressure on chair and bed, resident to change position at urs and weekly skin check by						
	8/27/15, indicated ulcer located on his measured 2.5 cent cm in width. This p healed on 10/16/15	cer Healing Chart initiated on R13 had developed a pressure s left buttock area which timeters (cm) in length by 2.0 pressure ulcer was noted to be 5. R13 had been on an every chedule from 8/28/15 - 9/25/15.						
	integrity as a proble directed staff to ap when in bed, repose observe skin integri report any reddene	ated 9/2/15, identified skin em area. The interventions ply foam boots on both feet sition R13 every two hours, rity with cares and bathing and ed, or open areas. The care on 4/25/15, R13 had right						

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	12/22/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245502	B. WING		11/:	25/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	INITY		201 9TH STREET WEST ADA, MN 56510		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 314	lower extremity stag history of a stage tw the care plan indica hospice services. H to reposition R13 at when needed. R13's Physician Or 11/25/15, identified anemia, anxiety, ch calf, dementia, hea The report also dire offload (relieve pres hours or more ofter affected area. In ac ulcers should be m weekly. R13's Braden Scale resident's level of ri pressure ulcer) date was at a high risk for ulcer. Interventions protectors, pressure bed, every two hour program, dressing o ointments. R13's Tissue Tolera determine the skin's without change) da should be placed of turning/repositionin	e (tool used to asses a isk for development of a edsured and documented on dotted and documented on easured and documented on extra distribution of a pressure to a pressure and the distribution of a pressure of a pressure and the extra distribution of a pressure s included bilateral heel e relieving devices to chair and r turning/repositioning changes and application of a nevery two hour	F 314			

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		AND HUMAN SERVICES				FORM	12/22/2015 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		245502	B. WING			11/2	25/2015
NAME OF	PROVIDER OR SUPPLIER	<b>.</b>		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	NITY			201 9TH STREET WEST ADA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	(NA)-B was observ proceed to assist R had a blue foam bo calf elevated on a p morning cares by w hands upon instruc changed R13's inco was observed to ha ulcers (partial thick as a shallow open of bed, without slough the right over the bo buttocks. NA-A ap and barrier spray to clean brief. -At 8:15 a.m. NA-B to R13's wheelchair relieving cushion in -At 8:38 a.m. NA-B to R13's wheelchair relieving cushion in -At 8:38 a.m. NA-B to R13's wheelchair relieving cushion in -At 8:38 a.m. NA-B common area and near the fire place. his right foot. -At 9:10 a.m. R13 c trained medication another blanket and R13 remained seat common area, until transported R13 ba -At 10:13 a.m. TMA registered nurse (R change to R13's rig seated in the whee change.	ed to enter R13's room and R13 with morning cares. R13 bot on his left foot with his right billow. R13 participated in his vashing his own face and tion by NA-B. When NA-B bottinent brief, R13's buttocks ave two stage II pressure ness loss of dermis presenting ulcer with a red or pink wound n), one on the left and one on ony prominences of his plied a thin layer of ointment o R13's bottom and applied a transferred R13 from the bed r which had a pressure its seat. transported R13 out into the positioned R13's wheelchair R13 had a blue foam boot on complained of being cold and aide (TMA)-B retrieved d placed over R13's shoulders. ted in his wheelchair in the I 10:10 a.m. when TMA-B	F	314			

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		AND HUMAN SERVICES				FORM	12/22/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245502	B. WING			11/2	25/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	NITY			01 9TH STREET WEST \DA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 314	far as RN-B was av current breakdown -At 10:28 a.m. RN-I were measured we The weekly wound herself, the director other RN. RN-B ve assessments includ wound and docume Pressure Ulcer Hea On 11/24/15, at 10: minutes since R13 TMA-B and RN-B to wheelchair back to R13's dry brief and areas on his buttoc reddened. TMA-B and RN-B measure verified the pressur measured 0.7 cm in the pressure ulcer of 0.8 cm. RN-B confu ulcers where new. R13's weekly skin a located in the residu the electronic media following: 11/5/15, assess stasis ulcer on right with black eschar (a foot near the small other skin was in fa open areas on R13 11/12/15, assess	ware R13 did not have any on his bottom now. B confirmed pressure ulcers ekly during wound rounds. rounds were conducted by r of nursing (DON) and the erified the weekly wound ded measurements of the entation of the wounds on the aling Chart. 40 a.m. (two hours and 25 had last been repositioned) ransferred R13 from the R13's bed. RN-B removed confirmed R13 had two open ks and R13's bottom was retrieved a measuring tape ed both open areas. RN-B re ulcer on the right side n length x 0.6 cm in width and on the left measured 0.7 cm x firmed both of these pressure and pain assessment notes ent progress note section of cal record indicated the sment completed by TMA-B - t lateral lower leg; right great a dry dark scab); right lateral toe had a darken scab, all air condition (no mention of any	F 3	314			

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		AND HUMAN SERVICES				FORM	12/22/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245502	B. WING			11/:	25/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
BENEDI	CTINE CARE COMMU	NITY			01 9TH STREET WEST \DA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 314	right lateral lower let toe black; right later a small eschar cap that had a darkened buttocks (location o measurement or sta * 11/16/15, hosp by RN-D identified I and foot wounds, he buttock wound. • 11/20/15, asses indicated status ulc measured 23.5 cm toe remained black started to turn black cap; back of the he 3.5 cm x 2.0 cm; or (location of wound n measurement or sta On 11/24/15, at 12: was at risk for the o ulcer. In addition, F aforementioned pro had indicated R13 f buttock and stated a new open area and On 11/24/15, at 12: pressure ulcers on pressure ulcers on say, with the interve pressure ulcer could stated anyone who should have been p	<ul> <li>Ag, right great toe and second ral foot near the small toe had and a small area on his heel d scab and one open area on of wound not specified nor a age identified) pice progress note completed R13's lower right leg wound owever, failed to identify</li> <li>Ages and completed by LPN-A ter on right lateral lower leg x 5.5 cm x 2.0 cm; right great ; other toes on right foot have k; lateral right foot has eschar el had opened and measured ne open area on buttocks not specified nor a age identified).</li> <li>A7 p.m. RN-B confirmed R13 development of a pressure</li> </ul>	F 3	\$14			

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	à	COM	PLETED
		245502	B. WING			11/25/2015	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BENEDIC	TINE CARE COMMU	NITY			201 9TH STREET WEST ADA, MN 56510		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETION DATE
F 314	Continued From pa	ae 26	F 3	21/			
		o an every one hour	1.0				
	turning/repositioning						
		er Skin Note dated 11/24/15,					
	verified R13 had tw which measured:	o open areas on buttocks					
	• right - 0.5 cm x						
	• left - 0.6 cm x 0	0.7 cm					
	$\Omega$ n 11/24/15 at 1.5	0 p.m. RN-B and the DON					
	confirmed it was the	eir expectation for staff to					
		an with regards to R13's on ing schedule and other					
		ention interventions.					
		8 a.m. NA-B stated R13 ned every two hours and if any					
	breakdown was not	iced, staff were to inform the					
		VA-B was unaware that R13's g scheduled had been					
	changed from every	y two hours to every one hour					
	as stated by niv-D (	on 11/24/15, at 12:52 p.m.					
	On 11/25/15, at 9:14	4 a.m. TMA-A stated R13					
	should be turned an	nd repositioned every two					
	hours. TMA-A was turning/repositioning	g schedule had been changed					
	from every two hou	rs to every one hour as stated					
	by RN-B on 11/24/1	o, at 12.02 p.m.					
	R13's care plan pro	vided on 11/25/15, by the					
	DON failed to reflect	t the change from an every					
		ing/returning schedule to an ositioning/turning schedule as					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED
		245502	B. WING _			11/2	25/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	CTINE CARE COMMU	NITY		-	11 9TH STREET WEST DA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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) COMPLETION DATE
F 314		ge 27 11/24/15, at 12:52 p.m.	F 3 <sup>-</sup>	14			
	(undated) indicated necessary turning a specific needs to pr pressure ulcers, pre pressure ulcers and ulcer development. skin was impaired r and once the area b	g and Repositioning policy residents would receive the and repositioning to meet the romote healing existing event reoccurrences of d to prevent new pressure In addition, if a resident's related to a pressure ulcer, had healed, the resident would and repositioning schedule of six months.					
F 329 SS=D	dated 2/25/11, indic notification/observa immediately. Follow accomplished at lea change in the ulcer tolerance to pressu improved.	ure Ulcer Assessment policy ated staff would document the tion of any pressure ulcer w up documentation would be ast weekly or upon significant area. In addition, tissue re would be maintained and EGIMEN IS FREE FROM RUGS	F 32	29			1/4/16
	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the	g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of neces which indicate the dose or discontinued; or any e reasons above.					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVE COMPLETED		
		245502	B. WING		11/25/201		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
BENEDI	CTINE CARE COMM	UNITY		201 9TH STREET WEST ADA, MN 56510			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE		
F 329	resident, the facilit who have not used given these drugs therapy is necessa as diagnosed and record; and reside drugs receive grad behavioral interver	age 28 y must ensure that residents d antipsychotic drugs are not unless antipsychotic drug ary to treat a specific condition documented in the clinical nts who use antipsychotic dual dose reductions, and ntions, unless clinically an effort to discontinue these	F 329				
	by: Based on observa review the facility f behaviors and iden pharmacological ir (R49) who receive anti-anxiety medic failed to monitor th hypnotic medication recieved a hypnoti lacked documenta of the medication. Findings include: R49 received PRN medication) and ta nonpharmacologic	ENT is not met as evidenced ation, interview and document called to identify target ntify and implement non nterventions for 1 of 1 resident d an as needed (PRN) ation. In addition, the facility be sleep pattern for the use of on for 1 of 1 resident (R5) who c, had a dose change and tion related to the effectiveness I lorazepam (antianxiety urget behaviors and cal interventions had not been stently implemented.		R49 will have clearly outlined target behaviors and outlined non-pharmaceutical interventions to before the use of PRN anti-anxiety medication according to their plan o R5 will have proper monitoring of sle pattern with current use of hypnotic according to their plan of care. All residents will not receive psychotrop drugs unless psychotropic drug ther necessary to treat a specific conditio diagnosis and non-pharmacological interventions are tried prior to administering medication. All reside receive proper monitoring of sleep patterns with current use of hypnotic medications according to plan of ca DON/Designee will ensure that all psychotropic medications will have to behaviors listed in the order of the medication specified to be given for	o trial f care. eep bic rapy is on or nt will c re. target		

Facility ID: 00413

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	<u>RS FOR MEDICARE</u> OF DEFICIENCIES	<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MELTIF	PLE CONSTRUCTION		0938-03
	OF CORRECTION	IDENTIFICATION NUMBER:		B		PLETED
		245502	B. WING		11/2	25/2015
AME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ENEDI	CTINE CARE COMMU	JNITY		201 9TH STREET WEST ADA, MN 56510		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETI DATE
F 329	R49's admission M 8/31/15, indicated I impairment, showe behavior towards s had received one of medication during f period of this asses R49's Psychotropio Assessment (CAA) was at risk for side antianxiety medica identification of targ nonpharmacologica implemented prior antianxiety medica R49's care plan ide area for psychotrop interventions direct effects of the psych physician and phar per guidelines for g care plan lacked id for the use of the F nonpharmacologica attempted prior to t antianxiety medica	linimum Data Set dated R49 had severe cognitive ed no signs of psychosis or self or others. In addition, R49 dose of PRN antianxiety the seven day observation ssment. C Medication Use Care Area ) dated 8/31/15, indicated R49 effects due to the use of an tion. The CAA lacked get behaviors and al interventions to be to the administration of the tion. entified on 8/18/15, a problem bic medication use. The ted staff to monitor for side notropic medication and for the macist review to be conducted gradual dose reduction. R49's lentification of target behaviors PRN lorazepam and al interventions to be the administration of the tion.	F 325		inges ors and a as well Staff neeting erform c use and rentions in time ed on all to e for 30 ly g monthly be	

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		AND HUMAN SERVICES				FORM	12/22/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245502	B. WING			11/25/2015	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
BENEDIC	CTINE CARE COMMU	NITY			01 9TH STREET WEST \DA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 329		-	F3	329			
		<ul> <li>However, the order had not arget behaviors for the use of n.</li> </ul>					
	medications dated mg PRN up to two t section of the conse target behaviors be	asent for psychotropic 1/17/15, listed lorazepam 0.5 times a day for anxiety. The ent form which requested that e noted in specific terms, n of target behaviors for the m.					
	dated 9/1/15 - 11/25 received lorazepam 9/24/15, 10/5/15, 10 lorazepam 0.5 mg H variety of reasons s self-transferring, res R49's medical reco regards to nonphar attempted prior to the	tions Administration History 5/15, indicated R49 had n 0.5 mg on 9/13/15, 9/14/15, 0/19/15, and 10/29/15. The had been administered for a such as picking her nose, stlessness and yelling out. rd lacked documentation with macological interventions he administration of the /14, 9/14/15, and 10/29/15.					
	the dining room, se	1 a.m. R49 was observed in ated in her wheelchair. R49 is oxygen on and eating her lently.					
	seated in a recliner	8 a.m. R49 was observed by the fireplace in the 9 had her feet elevated, s closed.					

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	-	AND HUMAN SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	ING	à	COM	PLETED
		245502	B. WING			11/25/2015	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	CTINE CARE COMMU	NITY			201 9TH STREET WEST ADA, MN 56510		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG		( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLÉTION DATE
F 329	Continued From pa	ae 31	F 3	200			
		0 p.m. trained medication aide	10/	20			
	(TMA)-B stated R49	9 received the PRN lorazepam					
		ed to self-transfer because up and go to the bathroom.					
	TMA-B confirmed F	R49 lacked identification of					
		al interventions to be he administration of the PRN					
	lorazepam. TMA-B	stated they just would try					
	different things.						
	(RN)-B confirmed ta	3 p.m. registered nurse arget behaviors and					
	specifically identifie	al interventions had not been d or consistently documented the PRN lorazepam for R49.					
	RN-B stated the lice	ensed social worker (LSW)-A					
	care plan which wo	he psychotropic portion of the uld list the target behaviors					
	and nonpharmacolo	ogical interventions.					
		0 p.m. the consulting					
		ated target behaviors and al interventions should have					
	been identified and	consistently utilized for R49's					
	PRN use of the lora	azepam.					
	$O_{\rm P} = 11/25/15$ at 9.2	0 a.m. LSW-A confirmed					
	target behaviors an	d nonpharmacological					
	interventions had no for R49's PRN use	ot been specifically identified					
	No policy on the de	velopment and					
	implementation of t	arget behaviors and					
	nonpharmacologica	al interventions was provided.					

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES O								
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY			
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		C	COMPLETED		
		245502	B. WING			1	1/25/2015		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
BENEDIO	CTINE CARE COMMU	NITY			201 9TH STREET WEST ADA, MN 56510				
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT		(X5)		
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE		
F 329	Continued From pa	ge 32	F3	329					
		lacked sleep pattern continued use of a hypnotic							
	was diagnosed with insomnia. The MDS cognition and require	dated 8/23/15, indicated R5 diabetes, a stroke and also indicated R5 had intact red extensive assistance with ers and was unable to							
	started on 11/28/14 medication). The o was decreased to 1 11/6/15. The orders	ians orders included an order , for Zaleplon (hypnotic rders indicated the medication 0 milligrams at bedtime on s also directed staff to chart vior and pattern if it had							
		d 12/22/14, directed staff to for insomnia and monitor for							
	had been evaluated Zaleplon was decre	e dated 11/6/15, indicated R5 d by the psychiatrist and the eased to 10 mg at bedtime as it ease in sleep apnea.							
	indicated R5 had no frequently up throug displayed irritability	c notes dated 11/12/15, ot been sleeping well and was ghout the night. R5 had towards the staff and rs. A sleep study was ordered							

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245502	B. WING			11/:	25/2015
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	CTINE CARE COMMU	NITY			201 9TH STREET WEST ADA, MN 56510		
(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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From pa at that time.	ge 33	F 3	329			
		lacked any indication of sleep and / or documentation.					
	difficulty sleeping an scheduled for Dece nurses were to be c since the hypnotic r reduced on 11/6/15 progress notes / clin facility had not docu	24 p.m. RN-A stated R5 had nd a sleep study had been mber 2015. She stated the locumenting his sleep pattern nedication had just been . RN-A then reviewed R5's nical record and confirmed the imented on R5's sleep patter n dose had been changed.					
	went to bed around	0 p.m. R5 stated he routinely 6:00 p.m. He stated he only cook the medications.					
F 406 SS=D	requested and none 483.45(a) PROVIDI	E/OBTAIN SPECIALIZED	F 4	106			1/4/16
	not limited to, physic pathology, occupati health rehabilitative and mental retardat resident's comprehe must provide the re required services fr accordance with §4	ilitative services such as, but cal therapy, speech-language onal therapy, and mental services for mental illness ion, are required in the ensive plan of care, the facility quired services; or obtain the om an outside resource (in 83.75(h) of this part) from a zed rehabilitative services.					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	0	(X3) DATE	SURVEY
				G		00111	
		245502	B. WING _			11/2	25/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE		
BENEDIC	CTINE CARE COMMU	NITY		201 9TH STREET WEST			
				ADA, MN 56510			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
F 406	Continued From pa	ge 34	F 40	6			
	by:	NT is not met as evidenced ion, interview and document		R58 has been discha	raed and cou	nties	
		ailed to ensure a level II		have been contacted t			
	Preadmission Scree	ening and Resident Review		screening. An audit wa			
		bleted for 1 of 1 resident (R58)		12/14/2015 on all curr			
	who was assessed	with intellectual disabilities.		ensure they didn t trig screen prior to admiss			
				resident triggered for a			
	Findings include:			To ensure this incident	t will not happ	ben	
				again the facility will no			
	Sanford Medical Ce diagnoses included disorder characteriz and chronic feeling delayed and anxiety	sult note dated 10/27/15, from enter Fargo indicated R58's Prader-Willi (rare genetic zed by cognitive disabilities of hunger), developmentally y. R58 had resided in a group dmission to the hospital.		triggers for a LEVEL II having documentation completed prior to adr Policy is consistent with LSW was educated or LEVEL II screen require LSW educated DON a for admissions on 1/16 documentation will be	that the scre nission. Curre th this process the process rements for M as DON is bac 6/15 .All LOC reviewed on	een ent of /IN law. ck up new	
		e dated 11/6/15, indicated R58 equired extensive assist with ng.		Admissions monthly a beginning January. If a triggered for a level II be conducted to ensur completed prior to adr	a resident has screen and a re a screen w	s udit will	
	(PAS/OBRA Level I Level II Developme final review of the n	hission Screening Assessment ) dated 11/5/15, indicated a ntal Disability Evaluation and eed for specialized services ucing a check mark next to the					
	11/20/15, had been	54 p.m. a late entry for entered into R58's resident icensed social worker					

If continuation sheet Page 35 of 49

		AND HUMAN SERVICES				FORM	: 12/22/2015 APPROVED
	<u>SFOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUI	TIPI	LE CONSTRUCTION		. 0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:				· · · /	IPLETED
		245502	B. WING			11/	25/2015
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		25/2015
BENEDIC	TINE CARE COMMU	NITY			201 9TH STREET WEST		
				A	ADA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
E (00							
F 406	Continued From pa	ge 35 e indicated a message had	F 4	106			
		an county social services					
		ate on the level II PASRR					
	screening for R58.						
	On 11/00/15 at 0:1	0 mm DE0 was sheen ad					
		0 p.m. R58 was observed chair yoga activity in the					
	common area.	, , ,					
		2 p.m. R58 was seated in the					
		r wheelchair where she ate a ed with staff and other					
	residents.						
		3 a.m. a late entry for					
		entered into R58's resident _SW-A indicating another					
	message had been	left with NCSS regarding the					
	PASRR screening f	or R58.					
		e dated 11/24/15, at 9:53 a.m. ad contacted NCSS and the					
		ve had confirmed the level II					
		hadn't been completed and					
	She was yoing to cr	neck with her supervisor.					
	$O_{\rm D}  11/24/15$ at 11.0	20 a.m. D59 was sheared in					
		30 a.m. R58 was observed in partment participating in a					
	therapy session.						
		3 a.m. LSW-A confirmed					
		R screening had not been stated she thought the county					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245502	B. WING			11/	25/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		20/2010
BENEDIC	CTINE CARE COMMU	NITY			01 9TH STREET WEST		
		TEMENT OF DEFICIENCIES		A	DA, MN 56510 PROVIDER'S PLAN OF CORRECTION		0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 406			-	~ ~			
F 406	Continued From pa	ge 36 nplete this screening. LSW-A	F 4	06			
		epresentative had informed her					
		iscommunication and the					
		ening for R58 had been e, LSW-A was unaware of					
	when the screening	would be completed.					
	-	0 a.m. R58 was observed in					
		ing her breakfast. R58 stated job at the occupational					
		r (ODC) where she placed					
	labels on papers an	nd also put papers in a R58 stated she missed her					
	job.	R58 stated sne missed her					
	<b>)</b>						
	The Admission Pres	screening for Individuals with					
	Mental Retardation	or Mental Illness dated 4/12,					
		facility was not to admit any					
		ellectual or developmental prity had determined prior to					
	admission that the i	individual required that level of					
		the facility and whether or not red specialized services.					
F 428	-	EGIMEN REVIEW, REPORT	F 42	28			1/4/16
SS=D	IRREGULAR, ACT	ON					
	The drug regimen o	of each resident must be					
	reviewed at least or	nce a month by a licensed					
	pharmacist.						
		st report any irregularities to					
		cian, and the director of reports must be acted upon.					
	narong, and mose						

Facility ID: 00413

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		AND HUMAN SERVICES				FORM	12/22/2015 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245502	B. WING			11/2	25/2015
NAME OF I	PROVIDER OR SUPPLIER	1			TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	INITY			D1 9TH STREET WEST DA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	Continued From pa	ige 37	F 4	28			
	by: Based on interview facility failed to ens the lack of target b pharmacological im prior to the adminis anti-anxiety medica who received anti-a aforementioned ide pharmacist failed to pattern monitoring received hypnotic m Findings include: R49 recieved PRN medicaiton) withour of the medication ic pharmacological im prior to the adminis R49's admission M 8/31/15, indicated F impairment, showe behavior towards s had received one d medication during t period of this asses R49's psychotropic Assessment (CAA)	terventions to be attempted stration of an as needed (PRN) atton for 1 of 1 resident (R49) anxiety medications without the entified. In addition the b identify the lack of sleep for 1 of 1 resident (R5) who nedications. lorazepam (antianxiety t target behaviors for the use dentified nor non terventions to be attempted stration of the medication. inimum Data Set (MDS) dated R49 had severe cognitive d no signs of psychosis or elf or others. In addition, R49 lose of PRN antianxiety he seven day observation			R49 will have non- pharmacological interventions listed in her progress in prior to giving her prn anxiety medic R5 had sleep monitoring put in plac reflect his sleep after the change in hypnotic starting on 12/16/15. DON/designee will ensure that all residents on prn psychotropic medic have documentation on non-pharmacological interventions prior giving medication and residents with changes in hypnotics will be monito sleep by educating staff at monthly meeting on 12/16/15. DON/designee audit all prn psychotropic weekly to ensure proper documentation is pre and educate staff with just in time tr as needed. DON/designee will aud residents with changes in sleep medications at our monthly psychot meeting. Pharm D will audit that residents with hypnotic changes will have sleet monitoring completed on her month Pharm D will also audit that all reside who receive prn psychotropic have progress notes listed on her monthl and report her findings to the DON. will be reviewed at Quality Council of 1/20/16.	note cation. e to cations to h red for staff ee will esent caining it cropic sidents ep nly visit. dents y visit Audits	

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		AND HUMAN SERVICES				FORM	: 12/22/2015 APPROVED : 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245502	B. WING	ì		11/:	25/2015
NAME OF I	PROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	NITY			201 9TH STREET WEST ADA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428	antianxiety medicati identification of targ nonpharmacologica implemented prior tantianxiety medicat R49's Physician Or 10/25/15-11/25/15, that included chron disease, anxiety dis dementia. In additi had ordered loraze could be given PRN generalized anxiety identified specific ta the PRN lorazepar R49's care plan ide area for psychotrop interventions direct effects of the psych physician and phan per guidelines for g care plan lacked ide for the use of the P nonpharmacologica attempted prior to t antianxiety medicat	tion. The CAA lacked get behaviors and al interventions to be to the administration of the tion. der Report dated indicated R49 had diagnoses ic obstructive pulmonary sorder, heart failure and on, on 8/18/15, the physician pam 0.5 milligrams (mg) that N up to three times a day for A However, the order had not arget behaviors for the use of n. entified on 8/18/15, a problem bic medication use. The ed staff to monitor for side notropic medication and for the macist review to be conducted tradual dose reduction. R49's entification of target behaviors 'RN lorazepam and al interventions to be he administration of the tion.	F	428			

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		AND HUMAN SERVICES				FORM	APPROVED
	CARE NEDICARE	& MEDICAID SERVICES	(XO) MU	דוחו	E CONSTRUCTION		0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
				-			
		245502	B. WING			11/2	25/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	CTINE CARE COMMU	NITY			01 9TH STREET WEST \DA, MN 56510		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
TAG			IAG		DEFICIENCY)		
			n 				
F 428	Continued From page	.ge 39	F 4	28			
	R49's PRN Medicat	tions Administration History					
		5/15, indicated R49 had					
		n 0.5 mg on 9/13/15, 9/14/15, 0/19/15, and 10/29/15. The					
		had been administered for a					
		such as picking her nose,					
		stlessness, and yelling out. rd lacked documentation with					
		macological interventions					
	attempted prior to the	he administration of the					
	lorazepam on 9/13/	(14, 9/14/15, and 10/29/15.					
		macists monthly medication					
		n 8/23/15 - 11/5/15, lacked					
		d for the identification of target bharmacological interventions					
		R49's PRN lorazepam.					
	On 11/24/15. at 3:4:	3 p.m. registered nurse					
	(RN)-B confirmed ta	arget behaviors and					
		al interventions had not been					
		d or consistently documented the PRN lorazepam for R49.					
		ensed social worker (LSW)-A					
		he psychotropic portion of the					
	and nonpharmacolo	uld list the target behaviors					
		gioar interventions.					
		0					
		0 p.m. the consulting onfirmed target behaviors and					
		al interventions should have					
	been identified and	consistently utilized for R49's					
		azepam. The CP stated she these were identified and					

		AND HUMAN SERVICES				FORM	12/22/2015 APPROVED
	CARENCIES			דוחו	E CONSTRUCTION		0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245502	B. WING			11/2	25/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	CTINE CARE COMMU	NITY			01 9TH STREET WEST NDA, MN 56510		
0(4) 15		TEMENT OF DEFICIENCIES		-	PROVIDER'S PLAN OF CORRECTION		(1/5)
(X4) ID PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI)		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
TAG	REGULATORY OR LS	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
F 428	Continued From page	ge 40	F 4	28			
		t of the monthly pharmacy					
	medication regime	reviews.					
		0 a.m. LSW-A confirmed					
		d nonpharmacological					
		ot been specifically identified use of the lorazepam.					
		150 01 1110 101 a20pann.					
	No policy on the dev	velopment and arget behaviors and					
		al interventions was provided.					
	P5's alinical record	lacked sleep pattern					
		continued use of a hypnotic					
	medication.						
	DE's questarly MDC	dated 9/02/1E indicated DE					
		dated 8/23/15, indicated R5 diabetes, a stroke and					
		S also indicated R5 had intact					
	<b>U</b>	red extensive assistance with					
	ambulate.	ers and was unable to					
	ambulate.						
		ians orders included an order , for Zaleplon (hypnotic					
		rders indicated the medication					
	was decreased to 1	0 mg at bedtime on 11/6/15.					
		ected staff to chart R5's					
	sleeping behavior a or not.	ind pattern if it had improved					
		d 12/22/14, directed staff to for insomnia and monitor for					
	side effects.						

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		AND HUMAN SERVICES				I	FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			PLE CONSTRUCTION		X3) DATI	E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG	3		COIVI	IPLETED
		245502	B. WING				11/2	25/2015
					STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST			
BENEDIC	CTINE CARE COMMU	NITY		1	ADA, MN 56510			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD B		(X5) COMPLETION DATE
F 428	Continued From pa	ge 41	F 4	128	3			
	had been evaluated Zaleplon was decre	e dated 11/6/15, indicated R5 d by the psychiatrist and the eased to 10 mg at bedtime as it ease in sleep apnea.						
	indicated R5 had no frequently up throug displayed irritability	c notes dated 11/12/15, ot been sleeping well and was ghout the night. R5 had towards the staff and ors. A sleep study was ordered						
		lacked any indication of sleep and / or documentation.						
	difficulty sleeping an scheduled for Dece nurses were to be c since the hypnotic r reduced on 11/6/15 progress notes and	24 p.m. RN-A stated R5 had nd a sleep study had been ember 2015. She stated the documenting his sleep pattern medication had just been . RN-A then reviewed R5's confirmed the facility had not 's sleep pattern since his ad been changed.						
	went to bed around	0 p.m. R5 stated he routinely 6:00 p.m. He stated he only took the medications.						
	indicated R5 was re	macist Progress Notes eceiving Zaleplon 15 mg at The pharmacist note dated						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       245502       B. WING       11/25/2015         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST ADA, MN 56510       201 9TH STREET WEST ADA, MN 56510       11/25/2015			AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/22/2015 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       BENEDICTINE CARE COMMUNITY     STREET ADDRESS, CITY, STATE, ZIP CODE       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE	E SURVEY
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       BENEDICTINE CARE COMMUNITY     201 9TH STREET WEST       ADA, MN 56510     ADA, MN 56510       (X4) ID PREFIX     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL     ID PREFIX     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE     (X5) COMPLETI			245502	B. WING			11/:	25/2015
BENEDICTINE CARE COMMUNITY     ADA, MN 56510       (X4) ID PREFIX     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX     ID PREFIX     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DETICIENCY MUST BE PRECEDED BY FULL     OPENING PREFIX     COMPLETI (EACH CORRECTIVE ACTION SHOULD BE DETICIENCY MUST BE PRECEDED BY FULL     OPENING PREFIX     OPENING (EACH CORRECTIVE ACTION SHOULD BE DETICIENCY     OPENING (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD SHOULD BE (EACH CORRECTIVE ACTION SHOULD SHOULD SHOULD SHOULD SHOULD SHOULD SHOULD S	NAME OF P	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETI	BENEDIC	CTINE CARE COMMU	ΝΙΤΥ					
DEFICIENCY)	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
F 428     Continued From page 42     F 428       11/5/15, indicated the Zalepion had been reduced and the staff were to continue to monitor sleep. However, the clinical record lacked documentation related to sleep pattern monitoring.     F 428       On 11/24/15, at 4:10 p.m. the CP stated she had identified the Zalepion had been decreased and staff were to monitor R5's sleep pattern. However, the CP confirmed she had not identified the lack of sleep pattern monitoring and had not directed the staff to monitor R5's sleep pattern.       The undated Pharmacist Medication Regimen Review policy directed the consultant pharmacist to review the medication regimen for each resident monthly. The policy did not direct the pharmacist to ensure the facility was monitoring each client for the continued need for the medication.     F 441       SS=D     SPREAD, LINENS     F 441       The facility must establish and maintain an Infection Control Program The facility must establish and maintain an Infection Control Program The facility must establish and maintain an Infection Control Program The facility must establish and reasmission of disease and infection.     F 441       (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility.     (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	11/5/15, indicated th and the staff were to However, the clinical documentation relation monitoring. On 11/24/15, at 4:10 identified the Zalepl staff were to monitod However, the CP co the lack of sleep pad directed the staff to The undated Pharm Review policy direct to review the medic resident monthly. To pharmacist to ensure each client for the co medication. 483.65 INFECTION SPREAD, LINENS The facility must ess Infection Control Pr safe, sanitary and co to help prevent the of disease and infect (a) Infection Contro The facility must ess Program under white (1) Investigates, contro in the facility; (2) Decides what pr	<ul> <li>a Zaleplon had been reduced o continue to monitor sleep.</li> <li>al record lacked ted to sleep pattern</li> <li>0 p.m. the CP stated she had lon had been decreased and or R5's sleep pattern.</li> <li>onfirmed she had not identified ttern monitoring and had not monitor R5's sleep pattern.</li> <li>hacist Medication Regimen ted the consultant pharmacist ration regimen for each The policy did not direct the re the facility was monitoring continued need for the</li> <li>I CONTROL, PREVENT</li> <li>tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.</li> <li>I Program tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation,</li> </ul>					1/4/16

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		AND HUMAN SERVICES			FORM	12/22/2015 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION NG		E SURVEY PLETED
		245502	B. WING		11/2	25/2015
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	INITY		201 9TH STREET WEST ADA, MN 56510		
(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 APPP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441	actions related to in (b) Preventing Spre (1) When the Infect determines that a r prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each d hand washing is ind professional practic (c) Linens Personnel must ha	ord of incidents and corrective nfections. ead of Infection tion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. It require staff to wash their irect resident contact for which dicated by accepted	F 4.	41		
	by: Based on observa review, the facility f hand washing tech wound care for 2 or observed during dr Findings include: R5 was observed to staff member failed washing during the	NT is not met as evidenced tion, interview and document called to ensure appropriate nique was performed during f 2 residents (R5, R13) essing change. o receive wound care and the d to perform appropriate hand provision of the treatment.		R13 will receive proper dressin with hand washing and new pai placed on prior to application of clean/sterile product. R5 will rec washing and new gloves prior to solution to heel and before re-a dressing. All residents will recei dressing changes with hand wa clean gloves prior to application clean/sterile products. DON/De ensure that LPN/TMA/RN staff completing proper hand washin dressing application by weekly a	r of gloves new eeive hand o applying oplying ve proper shing and of new signee will s g and	

Facility ID: 00413

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TATEMEN	OF DEFICIENCIES DF CORRECTION	KANDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	· · /	IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245502	B. WING _		11/	25/2015
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO		
BENEDI	CTINE CARE COMMU	JNITY		201 9TH STREET WEST ADA, MN 56510		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 441	(RN)-A was observed was seated in a what removed R5's foar the transparent dreater in the transparent dreater dreater in the t	red to approach R5 while he heelchair in his room. RN-A in boot, sock and peeled back assing covering a wound on the s not wearing gloves when she ressing. The wound was hick black scab (eschar) and RN-A measured the wound to (cm) by 1.3 cm. RN-A left the ditional dressing supplies. She edication nurse and asked for supplies. RN-A was not her hands prior to leaving the returned to the room, applied a p the wound and covered the dressing. RN-A was not gloves during the procedure. R5's sock and replaced the 0 a.m. RN-A opened the door, valked to the neighborhood shed her hands. 05 a.m. RN-A verified she had tring the dressing change nor er hands during the procedure. a should have been worn during to receive wound care and the d to perform appropriate hand e provision of the treatment.	F 44	with dressing changes to ens hand washing, dressing appli infection control measures ar for each resident. Care plans adjusted as changes are mad be educated at monthly staff 12/16/15. Audits will be revier Quality Council on 01/20/16.	cation and e completed will be de. Staff will meeting on	

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	<u>RS FOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES		LE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:			` '	MPLETED
		245502	B. WING		11	/25/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	JNITY		201 9TH STREET WEST ADA, MN 56510		
(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 SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 441	related ulcer on the changed twice a da On 11/24/15, at 10 aide (TMA)-B comp R13's right calf wor and transported R1 his hands in the ba of gloves. R13 ren beside his bed. TM floor facing R13. T from R13's right leg nurse (RN)-B enter TMA-B with R13's removed the dried R13's right leg. TM cleanser on the wo 4 inch by 4 inch (4) wound. TMA-B rar cleanser spray. RM retrieved a bottle of the sterile water int "dermal wound cleas spray the sterile water placed them in a ne dressings were satt serosanguineous (1) amounts of blood) gloves and/or wast three sterile packag and applied them to placed an ABD dre absorbent dressing dressings. While F	ssing to the non-pressure eright calf was ordered to be ay. (10 a.m. trained medication oleted a dressing change on und. TMA-B gathered supplies 13 to his room. TMA-B washed throom sink and donned a pair nained seated in his wheelchair <i>M</i> A-B situated himself on the TMA-B removed the foam boot g. At 10:13 a.m. registered red R13's room to assist dressing change. TMA-B bloody stained stockinet from <i>M</i> A-B sprayed dermal wound und and removed the adhered (4) gauze dressings from the n out of the dermal wound I-B left R13's room and f sterile water. RN-B poured to the spray bottled labeled anser." TMA-B continued to ater onto R13's wound and ning 4x4 gauze dressings and earby garbage. The 4x4	F 441			

If continuation sheet Page 46 of 49

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO	. 0938-0391
	E SURVEY IPLETED
245502 B. WING 11	25/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
BENEDICTINE CARE COMMUNITY       201 9TH STREET WEST         ADA, MN 56510	
(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL 	(X5) COMPLETION DATE
F 441       Continued From page 46 gloves, cleaned up the supplies and washed his hands in the bathroom sink.       F 441         On 11/24/15, at 10:25 a.m. TMA-B confirmed during R13's dressing change he had not removed his gloves nor washed his hands following the removal of the soiled dressings and application of the clean new dressings. TMA-B stated "he should have." RN-B confirmed TMA-B should have removed his gloves and washed his hands following the removal of the soiled dressings and TMA-B should have also put on a new pair of gloves prior to the application of the new dressings.         On 11/25/15, at 8:18 a.m. director of nursing (DON) confirmed she expected staff to follow the facility's Dry/Clean Dressing policy.         Handwashing policy (undated) directed staff to wash their hands after contact with material which may be contaminated and/or potentially infectious. Also to wash hands after a source of body fluids, muccus membranes, and removal of gloves.         Dry/Clean Dressings policy dated 2/14, directed staff to wash and dry their hands prior to conducting a dressing change; clean gloves should be donned; then the soiled dressings removed; the gloves should be pulled over the dressing and discarded into a plastic bag; hands should be washed and dried thoroughly; supplies opened; then hands washed and dried dagain and	

Facility ID: 00413

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		AND HUMAN SERVICES			FO	RM A	12/22/2015 PPROVED )938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED
		245502	B. WING			11/2:	5/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	NITY			11 9TH STREET WEST DA, MN 56510		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 441 F 465 SS=D	gloves should be re and dried following change. 483.70(h)	ige 47 ew clean dressings applied; emoved and hands washed completion of the dressing AL/SANITARY/COMFORTABL	F 4			1	1/4/16
		ovide a safe, functional, ortable environment for the public.					
	by: Based on observat failed to ensure wh maintained in a clea	NT is not met as evidenced tion and interview, the facility eelchair armrests were an, safe and sanitary condition (R49, R56, R7) who had torn, le arm rests.			R49, R56, & R7 all received new arm rests. All resident s w/c arm rest was audited by DON to ensure that they are good condition. All poor quality arm rest were replaced. DON/designee will audit arm rests monthly for poor quality and	ts	
	Findings include:				replace prn. Staff will be educated on 12/16/15 to report poor quality arm rest DON/designee for replacement. Audits	to	
		2 p.m. R49's right wheelchair ved very loose, wobbly.			will be report to Quality Council on 1/20/2016.		
		3 p.m. R56's wheelchair arm d uncovered with padding					
	seated in the whee	9 p.m. R7 was observed Ichair. R7's wheelchair arm d torn and cracked.					

If continuation sheet Page 48 of 49

		AND HUMAN SERVICES				FORM	12/22/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245502	B. WING _			11/2	25/2015
NAME OF I	PROVIDER OR SUPPLIER	•	· · · · · · · · · · · · · · · · · · ·	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	ΝΙΤΥ			1 9TH STREET WEST DA, MN 56510		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	Continued From pa	ge 48	F 46	65			
	Director (ED) obser wheelchairs and ve arm rest was missin and stated it would R56's arm rests we uncleanable paddir In addition, the ED torn / cracked with and in need of repa be replaced. -At 1:00 p.m. the El have a maintenanc monitoring of the w nursing staff were of to maintenance who of repair or replace facility did not have	45 p.m. the Environmental ved the aforementioned rified R49's right wheelchair ng screws and coming apart be fixed. The ED verified re uncovered with exposed, ng and they would be replaced. verified R7's arm rests were exposed padding, uncleanable ir. The ED stated they would D stated the facility did not e schedule specific for the heelchair arm rest rather, the directed to submit a work order en a wheelchair was in need ment. The ED stated the a policy and procedure enance of wheelchairs / arm					

If continuation sheet Page 49 of 49

Image: Status of Dependencies     (x1) PROVIDERSUPPLENCUA     (x2) MUTTINE CONSTRUCTION     (x2) MUTTINE CONSTRUCTION <td< th=""><th></th><th>MENT OF HEALTH</th><th></th><th></th><th>F</th><th>5502025</th><th>FORM</th><th>12/01/2015 APPROVED 0938-0391</th></td<>		MENT OF HEALTH			F	5502025	FORM	12/01/2015 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS. CITY. STATE, 2IP CODE       201 STH STREET WEST       ALME OF PROVIDER OR SUPPLIER       DENEDICTINE CARE COMMUNITY       ADAM       DEPERDICTINE CARE COMMUNITY       DEPERDICTINE CARE COMMUNITY       DEPERDICTINE CARE COMMUNITY       DEPERDICTINE CARE COMMUNITY       DEPERDICTION       PRETX       PRETX       PRETX       CARE COMMENTS       K 000       INITIAL COMMENTS       K 000       FIRE SAFETY       01 Main Building       A Life Safety Code Survey was conducted by the Minesota Department of Public Safety on November 24, 2015 betwen the hours of 13:00 and 18:30. At the time of this survey Benedicitine Care Community 01 Main Building was found in substantial compliance with the requirements for participation in Medicar/Medicard 42 CFR. Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NEPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.       The facility was surveyed as two buildings without a basement. The building was constructed in 2000 and was determined to be of Type 1(222) construction. The protected with quick response spinklers in accordance with NFPA 13 Standard for the Installed in of Automatic Spinklers 1999 edition. The facility has a fine alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for the unstalled in of Automatic Spinklers 1999 edition. The facility has a fine alarm system with NFPA 72 "The National Fire Protected with quick response spinklers in accord					(X2) MULTIPI	LE CONSTRUCTION		
BENEDICTINE CARE COMMUNITY         201 9TH STREET WEST           XAD, MN 66510         DEMONSTREE         SUMMARY STATEMENT OF DEFICIENCIES         DEFICIENCY MUST REPRECIDENCY MUST REPRECIDENCIES         PROVIDENS PLAN OF CORRECTION SHOULD BE         Construints         Construints <td></td> <td></td> <td>245502</td> <td></td> <td>B. WING</td> <td></td> <td>11/24</td> <td>/2015</td>			245502		B. WING		11/24	/2015
PREFIX TAG       (EACH DEDICIDENCY MUST BE PRECEDED BY FULL REGULATORY OL SCIENTRYING INFORMATION)       PREX TAG       (EACH DEDICIDENCY) ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE       COMBUTE DEFICIENCY)         K 000       INITIAL COMMENTS       K 000       K 000       FIRE SAFETY       Image: Comparison of the comparison of			IUNITY	201 9TH	I STREET			
FIRE SAFETY 01 Main Building A Life Safety Code Survey was conducted by the Minnesola Department of Public Safety on November 24, 2015betwen the hours of 13:00 and 16:30. At the time of this survey Benedictine Care Community 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medical at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NPPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The facility was surveyed as two buildings: Benedictine Care Community is a 1-story building without a basement. The building is separated from the Hospital Building with a 2-hour fire barriers. In 2013 a chapel/ assisted living building was constructed to the north of the care center, is 1-story, no basement and Type V (111) construction. The buildings are fully sprinkler protected with quick response sprinklers in accordance with NFPA 13 Standard for the installation of Automatic Sprinkler spotected with quick response sprinklers in accordance with NFPA 13 Standard for the installation of Automatic Sprinkler spotected with rotification and installed in accordance with NFPA 72 "The National Fire Ararrers"	PRÉFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL	REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETION
01 Main Building A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety on November 24, 2015betwen the hours of 13:00 and 16:30. At the time of this survey Benedictine Care Community 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The facility was surveyed as two buildings: Benedictine Care Community is a 1-story building without a basement. The building was constructed in 2000 and was determined to be of Type II(222) construction. The building is separated from the Hospital Building with a 2-hour fire barriers. In 2013 a chapel/ assisted living building was constructed to the north of the care center, is 1-story, no basement and Type V (111) construction. The buildings are fully sprinkler protected with NFPA 13 Standard for the Installation of Automatic Sprinklers 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition.	K 000	INITIAL COMMENT	ſS		K 000			
and 16:30. At the time of this survey Benedictine Care Community 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The facility was surveyed as two buildings: Benedictine Care Community is a 1-story building without a basement. The building was constructed in 2000 and was determined to be of Type II(222) construction. The building is separated from the Hospital Building with a 2-hour fire barrier and the nursing home is divided into 3 smoke compartments with 1-hour fire barriers. In 2013 a chapel/ assisted living building was constructed to the north of the care center, is 1-story, no basement and Type V (111) construction. The buildings are fully sprinkler protected with quick response sprinklers in based detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Other hazardous areas have automatic fire		01 Main Building A Life Safety Code						
Benedictine Care Community is a 1-story building without a basement. The building was constructed in 2000 and was determined to be of Type II(222) construction. The building is separated from the Hospital Building with a 2-hour fire barrier and the nursing home is divided into 3 smoke compartments with 1-hour fire barriers. In 2013 a chapel/ assisted living building was constructed to the north of the care center, is 1-story, no basement and Type V (111) construction. The buildings are fully sprinkler protected with quick response sprinklers in accordance with NFPA 13 Standard for the Installation of Automatic Sprinklers 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition.		November 24, 2015 and 16:30. At the til Care Community 0 substantial complia participation in Mec Subpart 483.70(a), 2000 edition of Nati Association (NFPA)	5betwen the hours of me of this survey Be 1 Main Building was nce with the requirer licare/Medicaid at 42 Life Safety from Fire ional Fire Protection ) Standard 101, Life	f 13:00 nedictine found in ments for 2 CFR, 2, and the Safety		: *		
quick response sprinklers in accordance with NFPA 13 Standard for the Installation of Automatic Sprinklers 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Other hazardous areas have automatic fire		Benedictine Care C without a basement constructed in 2000 Type II(222) constru- separated from the 2-hour fire barrier a divided into 3 smok fire barriers. In 201 building was constru- center, is 1-story, n	community is a 1-sto t. The building was 0 and was determine uction. The building wi Hospital Building wi and the nursing home compartments wit 3 a chapel/ assisted ucted to the north of	ry building to be of is th a e is h 1-hour living the care				
TAGADATADY DEPENDENCED DEPENDENCED DEDECKTATADEC COMATIDE THE MARMATE		quick response spr NFPA 13 Standard Automatic Sprinkler has a fire alarm sys the corridors and sy that is monitored for notification and inst 72 "The National Fi Other hazardous an	inklers in accordanc for the Installation of rs 1999 edition. The stem with smoke det paces open to the co r automatic fire depa- talled in accordance ire Alarm Code" 1999 reas have automatic	e with f facility ection in orridors artment with NFPA 9 edition. fire	NATURE	ΤΙΤΙΕ		(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.

	MENT OF HEALTH					FORM	12/01/2015 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE			PLE CONSTRUCTION 6 01 - NURSING HOME 01	(X3) DATE SU COMPLE	
		245502		B. WING		11/24	4/2015
	ROVIDER OR SUPPLIER				TATE, ZIP CODE		
BENEDI	CTINE CARE COM	IUNITY		I STREET N 56510	WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	Continued From pa detection that are o accordance with the 2007 edition. The s station smoke detect the room and at the with the Minnesota The fire alarm syste department notifica The facility has a ca census of 45 at the	age 1 n the fire alarm syste e Minnesota State Fi leeping rooms have ctors that annunciate nurse's station in ac State Fire Code 200 em has automatic fire tion.	re Code single e outside ccordance 7 edition. e nd had a	K 000			

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If continuation sheet Page 2 of 2

PRETX     Concent of the common one of t		MENT OF HEALTH			F	5502025	FORM	12/01/2015 APPROVED 0938-0391
NME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       201 9TH STREET WEST       DAMAGE OF PROVIDER OR SUPPLIER       DAMAGE OF PROVIDER OF DEFINITION       PARK       EACH DEFINITION CONFERNMENT OF DEFINITION OF PARK OF CORRECTOR ACTION SPORTURE PROVIDER OF ACTION SPORTUDE ENCORTOR OF DEFINITION OF THE RECEDUATION       PARK       EACH DEFINITION OF EPRESENCES       K 0000       INITIAL COMMENTS       FIRE SAFETY       02 Chapel Building       A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety on November 24, 2015 between the hours of 13:00 and 16:30. At the time of this survey Benedicitue Care Community Of Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(2), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care.       The facility was surveyed as two buildings: Benedictine Care Community is a 1-story building without a basement. The building was constructed in 2000 and was determined to be of Type II(222) construction. The building was constructed in 2 a chapel assisted living building was constructed to the north of the care center, is 1-story, no basement and Type V (111) construction.       The buildings are fully sprinkler protected with quick response sprinklers in accordance with NFPA 13 Standard for the installed in accordance with NFPA 13 Standard for the installed in accordance with NFPA 13 Standard for the installed in accordance with the coridors and spaces open to the coridors that it monitored for automatic fire department notif	-							
BENEDICTINE CARE COMMUNITY         201 9TH STREET WEST           X00100 PREDX TAX         EACH DEFICIENCY MUST BE PRECIDED BY FULL REQUESTOR OR LSC DEFINITIONS MERCINALIZING         ID PREVX         PROVIDER'S PLAN OF CORRECTION AUGULD BE CROSHER/TENDER OF THE RECOUNTED FOR THE RECOUNTED OR LSC DEFINITIONS MERCINALIZING         ID PREVX         PROVIDER'S PLAN OF CORRECTION AUGULD BE CROSHER/TENDER OF THE AUGULATION OR LSC DEFINITIONS MERCINALIZING         ID PREVX         PROVIDER'S PLAN OF CORRECTION (EACH OCRRECTIVE AUGULD BE CROSHER/TENDER)         CORRECTIVE AUGULD BE CROSHER/TENDER)         CROSHER/TENDER)         CROS			245502		B. WING		11/24	/2015
Prefer TAG     reach dencipation with the Precedence of the Precedence of the APPROPRIATE OLSC DENTRYING INFORMATION)     Prefer transformation     reach dencipation of the APPROPRIATE DEFICIENCY)     Commentation       K 000     INITIAL COMMENTS     K 000     K 000     FIRE SAFETY     Commentation     Commentation       02 Chapel Building     A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety on November 24, 2015 between the hours of 13:00 and 16:30. At the time of this survey Benedictine Care Community of 1 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483:70(a). Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101. Life Safety Code (LISC), Chapter 18 New Health Care.       The facility was surveyed as two buildings: Benedictine Care Community is a 1-story building without a basement. The building vas constructed in 2000 and was determined to be of Type II(222) construction. The building vas separated from the Hospital Building vith a 2-hour fire barrier and the north of the care center, is 1-story, no basement and Type V (111) construction.       The buildings are fully sprinkler protected with quick response sprinklers in accordance with NFPA 13 Standard for the Installation of Automatic Sprinklers 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification and Installed in accordence with NFPA 72 "The National Fire Alarm Code" 1999 edition.			/ /IUNITY	201 9TH	I STREET		×5.	
FIRE SAFETY 02 Chapel Building A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety on November 24, 2015 between the hours of 13:00 and 13:30. At the time of this survey Benedictine Care Community 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. The facility was surveyed as two buildings: Benedictine Care Community is a 1-story building without a basement. The building is separated from the Hospital Building with a 2-hour fire barrier and the nursing home is divided int 3 snoke compartments with 1-hour fire barriers. In 2013 a chapel/ assisted living building was constructed to the north of the care center, is 1-story, no basement and Type V (111) construction. The buildings are fully sprinkler protected with quick response sprinklers in accordance with NFPA 13 Standard for the Installation of Automatic Sprinklers protected with quick response sprinklers in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition.	PRÉFIX	(EACH DEFICIENCY MUST	F BE PRECEDED BY FULL	REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION
02 Chapel Building A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety on November 24, 2015 between the hours of 13:00 and 18:30. At the time of this survey Benedictine Care Community 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. The facility was surveyed as two buildings: Benedictine Care Community is a 1-story building without a basement. The building us constructed in 2000 and was determined to be of Type II(222) construction. The building is separated from the Hospital Building with a 2-hour fire barrier and the nursing home is divided into 3 smoke compartments with 1-hour fire barriers. In 2013 a chapel/ assisted living building was constructed to the north of the care center, is 1-story, no basement and Type V (111) construction. The buildings are fully sprinkler protected with quick response sprinklers in accordance with NFPA 13 Standard for the Installation of Automatic Sprinklers 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Other hazardous areas have automatic fire	K 000	INITIAL COMMENT	ГS		K 000			
Minnesota Department of Public Safety on November 24, 2015 between the hours of 13:00 and 16:30. At the time of this survey Benedictine Care Community 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. The facility was surveyed as two buildings: Benedictine Care Community is a 1-story building without a basement. The building was constructed in 2000 and was determined to be of Type II(222) construction. The building with a 2-hour fire barrier and the nursing home is divide into 3 smoke compartments with 1-hour fire barriers. In 2013 a chapel/ assisted living building was constructed to the north of the care center, is 1-story, no basement and Type V (111) construction. The buildings are fully sprinkler protected with quick response sprinklers in accordance with NFPA 13 Standard for the Installation of Automatic Sprinklers 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Other hazardous areas have automatic fire								
Benedictine Care Community is a 1-story building without a basement. The building was constructed in 2000 and was determined to be of Type II(222) construction. The building is separated from the Hospital Building with a 2-hour fire barrier and the nursing home is divided into 3 smoke compartments with 1-hour fire barriers. In 2013 a chapel/ assisted living building was constructed to the north of the care center, is 1-story, no basement and Type V (111) construction. The buildings are fully sprinkler protected with quick response sprinklers in accordance with NFPA 13 Standard for the Installation of Automatic Sprinklers 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition.	c	Minnesota Departm November 24, 2015 and 16:30. At the til Care Community 0 substantial complia participation in Med Subpart 483.70(a), 2000 edition of Nati Association (NFPA)	nent of Public Safety 5 between the hours me of this survey Be 1 Main Building was ince with the requirer dicare/Medicaid at 42 Life Safety from Fire ional Fire Protection ) Standard 101, Life	on of 13:00 nedictine found in ments for CFR, a, and the Safety				
quick response sprinklers in accordance with NFPA 13 Standard for the Installation of Automatic Sprinklers 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Other hazardous areas have automatic fire		Benedictine Care C without a basement constructed in 2000 Type II(222) constru- separated from the 2-hour fire barrier a divided into 3 smok fire barriers. In 201 building was constru- center, is 1-story, n	Community is a 1-sto t. The building was D and was determine uction. The building is Hospital Building wi and the nursing home ac compartments wit 3 a chapel/ assisted ucted to the north of	ry building d to be of is th a e is h 1-hour living the care	6			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		quick response spr NFPA 13 Standard Automatic Sprinkler has a fire alarm sys the corridors and sp that is monitored fo notification and inst 72 "The National Fi Other hazardous an	inklers in accordance for the Installation of rs 1999 edition. The stem with smoke det paces open to the co or automatic fire depa talled in accordance ire Alarm Code" 1999 reas have automatic	e with f facility ection in prridors artment with NFPA 9 edition. fire				

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.

		AND HUMAN SERV & MEDICAID SERVI					APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA		PLE CONSTRUCTION G 02 - CHAPEL	(X3) DATE S COMPLE	URVEY
		245502		B. WING		11/2	4/2015
	ROVIDER OR SUPPLIER	IUNITY	201 9TH	RESS, CITY, S I STREET N 56510	TATE, ZIP CODE WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE F BE PRECEDED BY FULL F INTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K 000	detection that are of accordance with the 2007 edition. The s station smoke dete the room and at the with the Minnesota	In the fire alarm syste e Minnesota State Fi leeping rooms have ctors that annunciate e nurse's station in ac State Fire Code 200 em has automatic fire	re Code single outside cordance 7 edition.	K 000	2		~
	The facility has a ca census of 45 at the	apacity of 49 beds ar time of the survey.	nd had a	×			
	The requirement at MET.	42 CFR, Subpart 48	3.70(a) is				
					000704		sheet Page 2 of 2

**a** 2

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 2 of 2

Printed: 12/01/2015



Electronically delivered December 10, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5502026

Dear Mr. Hoemberg:

The above facility was surveyed on November 23, 2015 through November 25, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number . 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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.

Benedictine Care Community December 10, 2015 Page 2

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 Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us**.

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.

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

## Sincerely,

## Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

Minnesc	ota Department of He	alth				
-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		00413	B. WING		11/2	5/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	NITY 201 9TH S ADA, MN	56510	ST		
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2 000	Initial Comments		2 000			
	****ATTEI	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 from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	PER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 12/18/15

Electronically Signed

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If continuation sheet 1 of 53

## PRINTED: 01/25/2016 FORM APPROVED

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00413	B. WING		11/2	25/2015
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	you electronically. is necessary for St enter the word "cor text. You must ther State licensure pro completion date, th	Alth orders being submitted to Although no plan of correctio ate Statutes/Rules, please rrected" in the box available for indicate in the electronic cess, under the heading he date your orders will be electronically submitting to the nent of Health.	n or			
	of this Department provider and the fo issued. Please ind correction that you	/15, and 11/25/15, surveyors 's staff, visited the above llowing correction orders are licate in your electronic plan o have reviewed these orders, te when they will be complete				
	the State Licensing federal software.	nent of Health is documenting g Correction Orders using ag numbers have been sota state statutes/rules for	3			
	column entitled "IE statute/rule out of o "Summary Stateme and replaces the "T correction order. T findings which are after the statement evidence by." Follo	number appears in the far left 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 statute 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." THIS ERAL DEFICIENCIES ONLY. NR ON EACH PAGE.	3			

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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	•	
BENEDIO	CTINE CARE COMMU	NITY	STREET WE N 56510	ST		
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2 000	Continued From pa	ige 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 560	MN Rule 4658.0409 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			1/31/16
	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The c must include the inc	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557 agraph (b).	n			
	by: Based on interview facility failed to develop behavior care plan behaviors and nong for 1 of 1 resident	ent is not met as evidenced , and document review, the elop a comprehensive which included target oharmacological interventions (R49) who received an as anxiety medication.		Corrected		
	Findings include:					
	area for psychotrop interventions direct effects of the psych physician and phan per guidelines for g	ntified on 8/18/15, a problem bic medication use. The ed staff to monitor for side notropic medication and for the macist review to be conducted radual dose reduction. R49's entification of target behaviors	ł			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00413	B. WING		11/25/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	INITY 201 9TH ADA, MI	STREET WES	т		
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2 560	Continued From pa	age 3	2 560			
		al interventions to be he administration of the				
	that included chron disease, anxiety dis dementia. In additi had ordered loraze could be given PRN generalized anxiety	indicated R49 had diagnoses ic obstructive pulmonary sorder, heart failure and ion, on 8/18/15, the physician pam 0.5 milligrams (mg) that N up to three times a day for V. However, the order had not arget behaviors for the use of				
	dated 9/1/15 - 11/2 received lorazepan 9/24/15, 10/5/15, 10 lorazepam 0.5 mg variety of reasons s self-transferring, re R49's medical reco regards to nonphar attempted prior to t	tions Administration History 5/15, indicated R49 had n 0.5 mg on 9/13/15, 9/14/15, 0/19/15, and 10/29/15. The had been administered for a such as picking her nose, istlessness and yelling out. ord lacked documentation with macological interventions the administration of the /14, 9/14/15, and 10/29/15.				
	(RN)-B confirmed t nonpharmacologica specifically identifie for the utilization of RN-B stated the lic usually developed t care plan which wo	3 p.m. registered nurse arget behaviors and al interventions had not been ed or consistently documented the PRN lorazepam for R49. ensed social worker (LSW)-A the psychotropic portion of the build list the target behaviors ogical interventions.				

Minnesota Department of Health STATE FORM

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If continuation sheet 4 of 53

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00413	B. WING		11/2	25/2015
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
ENEDI	CTINE CARE COMMU	INITY 201 9TH ADA, MN	STREET WE	ST		
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	age 4	2 560			
	target behaviors an interventions had n	0 a.m. LSW-A confirmed ad nonpharmacological ot been specifically identified for the PRN use of the				
	would have a comp included measurab resident's medical, needs. The care p services that would s highest practicab	ndated) indicated all residents prehensive care plan that le objectives to meet the mental and psychosocial lan would describe the l be furnished so the resident ' le physical, mental and being would be attained and				
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			1/31/16
	-	omprehensive plan of care I personnel involved in the t.				
	by: Based on observative review, the facility for turning and repositive by the care plan for identified at risk for failed to provide incomposition by the care plan for	ent is not met as evidenced ion, interview and document ailed to provide every two hour ioning assistance as directed r 1 of 3 residents (R13) pressure ulcers. The facility continence cares as directed r 1 of 3 residents (R3) who e with incontinence cares and	r	Corrected		

Minnesota Department of Health STATE FORM

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If continuation sheet 5 of 53

It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00413	B. WING		- 11/25/2015	
PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE	•	
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CTINE CARE COMMU	ADA, N	IN 56510			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	age 5	2 565			
(R15) observed wh	o required oral care				
Findings include:					
integrity as a proble apply foam boots o reposition R13 eve integrity with cares	em area and directed staff to n both feet when in bed, ry two hours, observe skin and bathing and report any				
(NA)-B was observ proceed to assist F had a blue foam bo calf elevated on a p morning cares by w hands upon instruc- changed R13's inco- was observed to ha ulcers, one on the I the bony prominent applied a thin layer to R13's bottom an -At 8:15 a.m. NA-B to R13's wheelchai relieving cushion in	ed to enter R13's room and R13 with morning cares. R13 bot on his left foot with his righ billow. R13 participated in his vashing his own face and tion by NA-B. When NA-B bottinent brief, R13's buttocks ave two stage II pressure eft and one on the right over ces of his buttocks. NA-A of ointment and barrier spray d applied a clean brief. transferred R13 from the be r which had a pressure its seat. transported R13 out into the	ht S Y d			
	OF CORRECTION PROVIDER OR SUPPLIER CTINE CARE COMMUNICATION SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From particular failed to provide ora (R15) observed what assistance as direct Findings include: R13's was not prover repositioning assisted plan. R13's care plan data integrity as a problet apply foam boots of reposition R13 ever integrity with caressisted reddened or open at On 11/24/15, at 8:00 (NA)-B was observer proceed to assister had a blue foam boots calf elevated on a prover morning cares by whands upon instruct changed R13's income was observed to has ulcers, one on the latter the bony prominent applied a thin layer to R13's wheelchait relieving cushion intervant oral section and the s	OF CORRECTION       IDENTIFICATION NUMBER:         00413       00413         PROVIDER OR SUPPLIER       STREET         CTINE CARE COMMUNITY       201 9T         ADA, M       SUMMARY STATEMENT OF DEFICIENCIES         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 5         failed to provide oral cares for 1 of 2 residents (R15) observed who required oral care assistance as directed by the care plan.         Findings include:         R13's was not provided every two hour repositioning assistance as directed by the care plan.         R13's care plan dated 9/2/15, identified skin integrity as a problem area and directed staff to apply foam boots on both feet when in bed, reposition R13 every two hours, observe skin integrity with cares and bathing and report any reddened or open areas.         On 11/24/15, at 8:03 a.m. nursing assistant (NA)-B was observed to enter R13's room and proceed to assist R13 with morning cares. R13 had a blue foam boot on his left foot with his rigi calf elevated on a pillow. R13 participated in his morning cares by washing his own face and hands upon instruction by NA-B. When NA-B changed R13's incontinent brief, R13's buttocks was observed to have two stage II pressure ulcers, one on the left and one on the right over the bony prominences of his buttocks. NA-A applied a thin layer of ointment and barrier spray to R13's bottom and applied a clean brief. -At 8:15 a.m. NA-B transferred R13 from the be to R13's wheelchair which had a pressure relieving cushion in its seat.	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         00413       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         21111       201 9TH STREET WEST ADA, MN 56510         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIDT BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PROVIDER'S PLAN OF (EACH DEFICIENCY WIDT BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREPEX TAG         Continued From page 5 failed to provide oral cares for 1 of 2 residents (R15) observed who required oral care assistance as directed by the care plan.       2 565         Findings include:       R13's was not provided every two hour repositioning assistance as directed by the care plan.       2 565         R13's care plan dated 9/2/15, identified skin integrity with cares and bathing and report any reddened or open areas.       ID R13's transport to hours, observe skin integrity with cares and bathing and report any reddened or open areas.         On 11/24/15, at 8:03 a.m. nursing assistant (NA)-B was observed to enter R13's room and proceed to assist R13 with morning cares. R13 had a blue foam boot on his left foot with his right calf elevated on a pillow. R13 participated in his morning cares by washing his own face and hands upon instruction by NA-B. When NA-B changed R13's incontinent brief, R13's buttocks was observed to have two stage II pressure ulcers, one on the left and one on the right over the bony prominences of his buttocks. NA-A applied a thin layer of ointment and barrier spray to R13's buttom and applied a clean brief. -At 8:15 a.m. NA-B transferred R13 from the bed to R13's wheelchair w	OF CORRECTION       IDENTIFICATION NUMBER:       A BUILDING:       COM         00413       B. WING       11//         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       201 9TH STREET WEST         ADA, MN 56510       ADA, MN 56510       PROVIDER'S PLAN OF CORRECTION AUGU DE BERGEDED BY FULL       PROVIDER'S PLAN OF CORRECTION AUGU DE BERGEDED BY FULL       PREENX         REGULATORY OF LSCIDENTFYWE INFORMATION       ID PREENX       CROSS-REFERENCED TO THE APPROPRIATE DEPROVED TO THE APPROPRIMATE DEPROVED TO THE APPROPRIMATE DEPROVED TO T

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
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2 565	his right foot. -At 9:10 a.m. R13 of trained medication another blanket an R13 remained seat common area, until transported R13 ba -At 10:13 a.m. TMA registered nurse (F change to R13's rig seated in the wheeler change. - At 10:40 a.m. (two R13 had last been RN-B transferred F to R13's bed. RN- confirmed R13 had buttocks and R13's TMA-B retrieved a measured both oper pressure ulcer on tailor length x 0.6 cm in the the left measured (C confirmed both of tailor) the left measured (DON) con expectation for statility of the second regards to R13's end	complained of being cold and aide (TMA)-B retrieved id placed over R13's shoulders ted in his wheelchair in the il 10:10 a.m. when TMA-B ack to his room. A-B with the assistance of RN)-B completed a dressing ght lower leg. R13 remained elchair during the dressing o hours and 25 minutes since repositioned) TMA-B and R13 from the wheelchair back B removed R13's dry brief and d two open areas on his s bottom was reddened. measuring tape and RN-B en areas. RN-B verified the the right side was 0.7 cm in width and the pressure ulcer o 0.7 cm x 0.8 cm. RN-B these pressure ulcers where	n			

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00413	B. WING		11/25/2015		
AME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
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2 565	Continued From pa	age 7	2 565				
	should be turned and repositioned every two hours.						
		ded incontinence cares every ted by the care plan.					
	area for bowel stat staff to toilet R3 ev extensive assist wi perineal cares twic incontinent episode identified on 7/28/1 status and directed assist with incontin	ntified on 2/11/15, a problem us. The interventions directe rery night before bed, provide ith managing incontinence an e a day and after each e. In addition, R3's care plan 15, a problem area for urinary d staff to provide extensive ience episodes and to check incontinent product every two	d				
	7:10 a.m. until 10:1 minutes). During the room lying on her to assistance. -At 7:21 a.m. dietan R3's room and place over bed table and DA-A lacked offerin -At 10:13 a.m. NA- into room and took of R3. NA-C started	as continuously observed from 13 a.m. (three hours and three his time, R3 remained in her back without personal care ry assistant (DA)-A entered ced a breakfast tray on the raised the head of the bed. Ing R3 toileting assistance. C knocked on the door, walke the breakfast tray from in from ed a bed bath on R3, then which was full of bowel ne.	ed				
		50 p.m. RN-B and the DON heir expectation for staff to					

If continuation sheet 8 of 53

	Dia Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00413	B. WING		11/2	25/2015
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	NITY	I STREET WES N 56510	т		
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2 565	Continued From pa	ge 8	2 565			
		n with regards to R3 being ged every two hours as re plan.				
		06 a.m. trained medication stated R3 should be checked two hours.				
	R15's was not prov the care plan.	ided oral cares as directed by	/			
	a deficit with self-ca of daily living (ADL' assist with persona	eed 9/16/15, identified R15 ha are performance with activities s) and required extensive I hygiene cares and directed uth cares due to Gouty tophi s) on R15's hands.				
	enter R15's room a personal cares. NA in her bed, provide NA-A utilized an ow her wheelchair. NA opened a denture of plate into her mouth dry with a thin line of of her mouth. Durin not offered or assis -from 7:53 a.m. to 9 consume breakfast common activity are	8 a.m. NA-A was observed to nd proceed to complete R15' -A was observed to bathe R1 personal cares and dress he er-head lift to transfer R15 to -A combed her hair and then lish and inserted R15's top n. R15's lips were observed of white matter at the corners g this observation R15 was ted with oral cares. 9:50 a.m. R15 was observed and was assisted to the ea and situated at one of the t offered or assisted with oral	s 5 r. to			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00413	B. WING		11/2	25/2015
NAME OF I	PROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, S	TATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	INITY	TH STREET WES MN 56510	Т		
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2 565	Continued From pa	age 9	2 565			
	not provide R15 or breakfast. NA-A sta	56 p.m. NA-A verified she did al cares before or after ated she usually used swabs clean R15's mouth and she that.	S			
		17 p.m. RN-A stated R15 provided oral cares as direc	ted			
	should have been	0 p.m. the DON stated R15 provided or offered oral care res. The DON confirmed R1 followed.	es			
	indicated each resi to incorporate iden appropriate profess each element of ca interventions where	are Plans policy dated 10/10 ident's care plan was design tified problem areas and the sional services responsible are. In addition, care plan e to be designed to address rces of the problem areas	ned e for			
	residents would ha which described th furnished to the res practicable physica	(undated) indicated all we a comprehensive care pl e services which were to be sident so the resident's high al, mental and psychosocial e attained and maintained.	;			
	The director of nursi develop and implement	THOD OF CORRECTION: sing (DON) or designee, co ment policies and procedure the care plan. The DON or	es			

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	NITY 201 9TH ADA, MN	STREET WE	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	designee, could pro staff related to the t implementation. Th	ovide training for all nursing imeliness of care plan e quality assessment and ee could perform random	2 565			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident				1/31/16
	by: Based on observati review, the facility fa of a wound cleansir after staff had repla product's container the potential to affe	ent is not met as evidenced on, interview and document ailed to ensure proper labeling ng product was maintained iced the contents of the with sterile water. This had ct residents (R5, R13, R38) wounds which required routine		Corrected		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00413	B. WING		11/2	25/2015
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
BENEDIC	TINE CARE COMMU	NITY	STREET WES	т		
	SUMMARY STA	ADA, MI TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	COMPLET DATE
2 830	Continued From pa	ge 11	2 830			
	Findings include:					
	11/25/15, identified chronic non-pressu R13's dressing to the	der Report dated 10/25/15 - R13's diagnosis as having a re ulcer to his calf. In additior his non-pressure related ulcer s ordered to be changed twice				
	aide (TMA)-B comp R13's right calf wou and transported R1 his hands in the ba of gloves. R13 rem beside his bed. TM floor facing R13. T from R13's right leg nurse (RN)-B enter TMA-B with R13's of removed the dried R13's right leg. TM cleanser (a first aid active ingredient of 0.13%) on the wou inch by 4 inch (4 x wound. TMA-B ran cleanser spray. RM retrieved a bottle of the sterile water int "dermal wound cleas spray the sterile wa removed the remai and placed them in right lateral lower left	10 a.m. trained medication bleted a dressing change on and. TMA-B gathered supplies 3 to his room. TMA-B washed throom sink and donned a pai nained seated in his wheelcha MA-B situated himself on the MA-B removed the foam boot g. At 10:13 a.m. registered ed R13's room to assist dressing change. TMA-B bloody stained stockinet from IA-B sprayed dermal wound antiseptic spray with the Benzethonium chloride nd and removed the adhered 4) gauze dressings from the nout of the dermal wound -B left R13's room and sterile water. RN-B poured to the spray bottled labeled anser." TMA-B continued to the onto R13's wound and ning 4 x 4 gauze dressings a nearby garbage. R13's ag stasis ulcer was visualized one; wound appeared raw and	d r 4			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00413	B. WING		11/25/2015	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		20/2010
BENEDI	CTINE CARE COMMU	JNITY 201 9TH ADA, MN	STREET WES	т		
(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 THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From particular continued From particular formation of the second state of t	age 12 e with small amounts of blood) ugh the 4 x 4 gauze dressings, serile highly absorbent stockinet. On 11/20/15, this red 23.5 centimeters (cm) in ide and 2.0 cm deep. TMA-B d three sterile packages of 4 x and applied them to R13's aced an ABD dressing over the ngs. While RN-B held the ABD TMA-B placed a new stockinet d dressings. TMA-B removed d up the supplies and washed throom sink. TMA-B brought (which included the spray hal wound cleanser, however erile water) back to the at the nursing station for	2 830			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00413	B. WING		— 11/25/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	NITY	I STREET WES N 56510	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 13	2 830			
	The director of nurs review and revise p to ensuring wound properly. The direc could develop a sys	HOD OF CORRECTION: sing (DON) or designee could olicies and procedures relate care products are labeled stor of nursing or designee stem to educate staff and ng system to ensure all d properly.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one	9			
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			1/31/16
	comprehensive res of nursing services	sores. Based on the ident assessment, the directo must coordinate the ursing care plan which	r			
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessary	ho has pressure sores y treatment and services to revent infection, and prevent veloping.				
	by: Based on observati review, the facility f	ent is not met as evidenced on, interview and document ailed to identify, assess and tate interventions for a resider	nt	Corrected		

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00413	B. WING		11/	11/25/2015	
ME OF F	PROVIDER OR SUPPLIER		ET ADDRESS, CITY, S	TATE, ZIP CODE		25/2015	
ENEDIC	CTINE CARE COMMU	INITY	TH STREET WES MN 56510	ST .			
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) COMPLET DATE	
2 900	Continued From pa	age 14	2 900				
	ulcers for 1 of 3 res	o stage II pressure related sidents (R13) who develope are ulcers at the facility. This narm for R13.					
	Findings include:						
	(MDS) dated 8/24/ cognitive impairme of bowel and bladd with bed mobility, t personal hygiene. as being at risk for had existing venou than one pressure pressure reducing	hange Minimum Data Set 15, indicated R13 had sever ent, was frequently incontine ler, required extensive assis ransferring, toileting and In addition, R13 was identif pressure ulcer development is and arterial ulcers and mo ulcer. Skin treatment includ device in R13's chair and be ioning program and pressur	nt st ied nt, ore ed ed,				
	8/26/15, indicated impairment and ha ulcers noted. Fact included provide as mobility, skin treatr integrity and report open areas to the or relieving devices in encourage/remind	ssessment (CAA) dated R13 was at risk for skin ad pressure ulcers and stasis ors for R13's care plan ssistance with cares and be ments as ordered, monitor s any reddened, irritated or charge nurse, pressure a chair and bed, resident to change position urs and weekly skin check b	d kin at				
						1	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB		E CONSTRUCTION		E SURVEY PLETED
		00413	B. WING	B. WING		25/2015
NAME OF I	PROVIDER OR SUPPLIER	S	TREET ADDRESS, CITY, S	STATE, ZIP CODE		
BENEDIO	CTINE CARE COMMU	INITY	01 9TH STREET WE DA, MN 56510	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU .SC IDENTIFYING INFORMATIC		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From page 15 8/27/15, indicated R13 had developed a pressure ulcer located on his left buttock area which measured 2.5 centimeters (cm) in length by 2.0 cm in width. This pressure ulcer was noted to be		y 2.0			
	healed on 10/16/15 one hour turning so	5. R13 had been on an chedule from 8/28/15 - 9 ated 9/2/15, identified sk	every )/25/15.			
	integrity as a proble directed staff to ap when in bed, repose observe skin integr report any reddene plan also indicated lower extremity sta history of a stage to the care plan indicat hospice services.	ared 9/2/15, identified sk em area. The interventi ply foam boots on both ition R13 every two hou- ity with cares and bathin on 4/25/15, R13 had rig sis (vascular) ulcers and wo gluteal ulcer. In add ated R13 was receiving Hospice services directed t least every two hours	ons feet rs, ng and are ght d ition, d staff			
	11/25/15, identified anemia, anxiety, ch calf, dementia, hea The report also dire offload (relieve pre hours or more ofte affected area. In a	rder Report dated 10/25 R13's diagnoses as ch pronic non-pressure ulca art failure and palliative of ected staff to reposition ssure to area) R13 ever n and to avoid pressure ddition, pressure and st leasured and document	ronic er to care. and/or y two to asis			
	resident's level of r pressure ulcer) dat was at a high risk f	e (tool used to asses a isk for development of a ed 11/17/15, indicated F or development of a pre s included bilateral heel	R13			

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00413	B. WING		11/	11/25/2015	
	PROVIDER OR SUPPLIER		DRESS, CITY, ST		11/2	25/2015	
	- NOVIDEN ON SOFFLIEN		STREET WES				
BENEDI	CTINE CARE COMMU	JNITY ADA, MN					
(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	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	age 16	2 900				
	protectors, pressure relieving devices to chair and bed, every two hour turning/repositioning program, dressing changes and application of ointments.						
	determine the skin without change) da	ance (assessment used to 's ability to withstand pressure ted 11/18/15, indicated R13 n an every two hour Ig scheduled.					
	(NA)-B was observ proceed to assist F had a blue foam bo calf elevated on a p morning cares by v hands upon instruc- changed R13's inco- was observed to ha ulcers (partial thick as a shallow open- bed, without slough the right over the b buttocks. NA-A ap and barrier spray to clean brief. -At 8:15 a.m. NA-B to R13's wheelchai relieving cushion in -At 8:38 a.m. NA-B common area and near the fire place. his right foot.	transported R13 out into the positioned R13's wheelchair R13 had a blue foam boot on					
	trained medication another blanket an	complained of being cold and aide (TMA)-B retrieved d placed over R13's shoulders. ted in his wheelchair in the					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY PLETED
		00413	B. WING			25/2015
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	•	
BENEDI	CTINE CARE COMMU	NITV	H STREET WES MN 56510	г		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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) COMPLET DATE
2 900	common area, until transported R13 ba -At 10:13 a.m. TMA registered nurse (R change to R13's rig seated in the wheel change. On 11/24/15, at 10:: stated they were bo on R13's buttocks. had had some oper far as RN-B was aw current breakdown -At 10:28 a.m. RN-F were measured wey The weekly wound herself, the director other RN. RN-B ve assessments includ wound and docume Pressure Ulcer Hea On 11/24/15, at 10: minutes since R13 TMA-B and RN-B tr wheelchair back to R13's dry brief and areas on his buttoch reddened. TMA-B and RN-B measure verified the pressur measured 0.7 cm in the pressure ulcer of	<ul> <li>24 a.m. RN-B and TMA-B stated in the assistance of the completed a dressing the lower leg. R13 remained lenair during the dressing</li> <li>24 a.m. RN-B and TMA-B stated in the past R13 never some some some some some some some some</li></ul>	as 3 as e n d x			

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00413	B. WING	B. WING		11/25/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE			
BENEDI	CTINE CARE COMMU	INITY	H STREET WES	т			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
2 900	Continued From pa	age 18	2 900				
nnesota D	located in the resid the electronic med following: • 11/5/15, asses stasis ulcer on righ with black eschar ( foot near the small other skin was in fa open areas on R13 • 11/12/15, asse practical nurse (LP right lateral lower la toe black; right later a small eschar cap that had a darkene buttocks (location of measurement or st * 11/16/15, hos by RN-D identified and foot wounds, h buttock wound. • 11/20/15, asse indicated status uld measured 23.5 cm toe remained black started to turn black started to t	ssment completed by license N)-A indicated stasis ulcer o eg, right great toe and secon ral foot near the small toe ha o and a small area on his hee ed scab and one open area o of wound not specified nor a tage identified) pice progress note complete R13's lower right leg wound however, failed to identify ssment completed by LPN-A cer on right lateral lower leg x 5.5 cm x 2.0 cm; right gre k; other toes on right foot hav k; lateral right foot has escha eel had opened and measure ne open area on buttocks not specified nor a tage identified).	- I I I I I I I I I I I I I I I I I I I				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00413	B. WING		11/25/20 <sup>-</sup>	
AME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		20/2010
BENEDIO	CTINE CARE COMMU	JNITY 201 9TH ADA, MN	STREET WES	т		
(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	ION SHOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	age 19	2 900			
	new open area and the ulcer was not measured.					
	pressure ulcers on pressure ulcers an say, with the interve pressure ulcer cou stated anyone who should have been turning/repositionin	:52 p.m. RN-B confirmed both R13's buttocks were stage II d even though it was hard to entions in place R13's Id have been avoidable. RN-B had a current pressure ulcer placed on an every one hour ng schedule. RN-B stated R13 to an every one hour ng schedule.				
	confirmed it was th follow R13's care p turning and reposit	50 p.m. RN-B and the DON leir expectation for staff to plan with regards to R13's ioning schedule and other vention interventions.				
	should be reposition breakdown was no medication nurse. turning/repositioning changed from ever	08 a.m. NA-B stated R13 oned every two hours and if any ticed, staff were to inform the NA-B was unaware that R13's ng scheduled had been ry two hours to every one hour on 11/24/15, at 12:52 p.m.	/			
		4 a.m. TMA-A stated R13 nd repositioned every two				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00413	B. WING		11/25/2015	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		20/2010
ENEDIC	CTINE CARE COMMU	JNITY 201 9TH ADA, MM	STREET WES	т		
(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 THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 20	2 900			
		ng schedule had been changed Irs to every one hour as stated				
	DON failed to reflect two hour reposition every one hour rep	ovided on 11/25/15, by the ct the change from an every ing/returning schedule to an iositioning/turning schedule as 11/24/15, at 12:52 p.m.				
	(undated) indicated necessary turning a specific needs to p pressure ulcers, pr pressure ulcers and ulcer development. skin was impaired and once the area	ng and Repositioning policy d residents would receive the and repositioning to meet the romote healing existing event reoccurrences of d to prevent new pressure . In addition, if a resident's related to a pressure ulcer, had healed, the resident would g and repositioning schedule of six months.				
	dated 2/25/11, india notification/observa immediately. Follo accomplished at le change in the ulcer	ure Ulcer Assessment policy cated staff would document the ation of any pressure ulcer w up documentation would be ast weekly or upon significant r area. In addition, tissue ure would be maintained and	9			
	The director of nurs	THOD OF CORRECTION: sing or designee, could review for pressure ulcers to assure				

ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER IDENTIFIC		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00413		B. WING		11/2	25/2015
AME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE	• •	
ENEDIC	TINE CARE COMMU	INITY	201 9TH S ADA, MN	STREET WE	ST		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 900	Continued From pa	ige 21		2 900			
	they are receiving t treatment/services from developing an pressure ulcers. Th designee, could con delivery of care to e services are impler pressure ulcer deve	to prevent pre- to promote he director of nduct random ensure approp nented to red	essure ulcers healing of nursing or audits of the priate care and				
	TIME PERIOD FOR (21) days.	R CORRECT	ION: Twenty-one				
2 920	MN Rule 4658.052	5 Subp. 6 B I	Rehab - ADLs	2 920			1/31/16
	Subp. 6. Activities comprehensive res home must ensure B. a resident who activities of daily liv services to maintain and personal and o	ident assess that: is unable to ing receives t n good nutritio	nent, a nursing carry out he necessary				
	This MN Requirements by: Based on observation review, the facility for assistance with bow cares for 1 of 3 res requires assistance addition, the facility 1 of 2 residents (Ro- with oral cares.	ion, interview ailed to provio wel and bladd idents (R3) re with incontin failed to prov	and document de timely er incontinence eviewed for who ence cares. In ride oral cares for		Corrected		
	Findings include:						

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00413	B. WING		11/25/2015	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE	11/20/2010	
BENEDIC	CTINE CARE COMMU	201 9TH	STREET WES			
(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 COMPLI THE APPROPRIATE DATE	
2 920	Continued From pa	age 22	2 920			
	R3 was not provide hours on the morni	ed incontinence care for over 3 ing of 11/24/15.	3			
	8/28/15, indicated l impairment, was fro and bladder, had lii lower extremities b extensive assistant transferring, toiletin Activity of Daily Liv Assessment (CAA) was frequently inco extensive assistant	mum Data Set (MDS) dated R3 had moderate cognitive equently incontinent of bowel mited range of motion in the ilaterally and required ce with bed mobility, ng and personal hygiene. R3's ing (ADL) Care Area ) dated 3/4/15, indicated R3 ontinent of urine, required ce with toileting and was on ar eting program throughout the				
	area for bowel stat R3 every night befor assist with managin cares twice a day a episode. In addition 7/28/15, a problem directed staff to pro- incontinence episo	ntified on 2/11/15, a problem us and directed staff to toilet ore bed, provide extensive ng incontinence and perineal and after each incontinence n, R3's care plan identified on a area for urinary status and ovide extensive assist with des and to check and change orief every two hours.				
	indicated R13 was bladder and that si toilet most of the tin	ssment dated 8/25/15, frequently incontinent of nce R13 refused to use the me she had been switched to schedule throughout the day.	a			
		ment dated 8/25/15, indicated y incontinent of bowel and that				

TATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00413	B. WING	B. WING		25/2015
AME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE	•	
ENEDIC	CTINE CARE COMMU		H STREET WES	Т		
(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) COMPLET DATE
2 920	Continued From pa	age 23	2 920			
		R13 had been changed to a check and change incontinence schedule.				
	11/25/15, indicated	nission Record printed on I R3's diagnoses to include ession, dysuria (painful or and constipation.				
	7:10 a.m. until 10:1 minutes). During th room lying on her k -At 7:21 a.m. dieta R3's room and plac over bed table and DA-A lacked offerin -At 10:13 a.m. nurs on R3's door, walk breakfast tray from proceeded to start	ry assistant (DA)-A entered ced a breakfast tray on the raised the head of the bed. ng R3 toileting assistance. sing assistant (NA)-C knocked ed into room and took the n in front of R3. NA-C R3's bath. when NA-C opene ief, the brief was full of bowel	e d			
		:50 a.m. NA-C stated R3 was incontinent brief changed and every three hours.				
	(RN)-B and the dire confirmed it was th follow R3's care pla	50 p.m. registered nurse ector of nursing (DON) leir expectation for staff to an with regards to R3 being ged every two hours.				
		:06 a.m. trained medication stated R3 should be checked				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00413	B. WING		11/25/20	15
NAME OF	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	INITY	I STREET WES N 56510	Т		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE CO THE APPROPRIATE	(X5) MPLET DATE
2 920	Continued From pa	ige 24	2 920			
	and changed every	two hours.				
	No policy related to checking and chan	incontinence care specific for ging was provided.	r			
	R15 was not provid care plan.	led oral care as directed by th	e			
	8/28/15, identified F and diabetes. The I moderate cognitive	imum Data Set (MDS) dated R15's diagnoses as depressio MDS also indicated R15 had impairment and required th personal hygiene cares.	n			
	a deficit with self-ca and required extens hygiene cares and	ted 9/16/15, identified R15 had are performance with ADL's sive assist with personal directed staff to provide mouth tophi (gout complications) on	h			
	enter R15's room a personal cares. NA in her bed, provide NA-A utilized an ov her wheelchair. NA a denture dish and her mouth. R15's lij thin line of white ma	8 a.m. NA-A was observed to nd proceed to complete R15's -A was observed to bathe R18 personal cares and dress her er-head lift to transfer R15 to -A combed R15's hair, opened inserted R15's top plate into ps were observed dry with a atter at the corners of her time R15 was not offered or ares.	5 5			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00413	B. WING	B. WING		25/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	NITY 201 9TH ADA, MI	STREET WES	Г		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' 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) COMPLET DATE
2 920	On 11/24/15, from 7 was observed to ea meal. Following bre the common activity the tables. During th or assisted with ora On 11/24/15, at 1:5 not provide oral car cares or following th stated she usually u to clean R15's mou that. On 11/24/15, at 2:1 cares should have had or during morning care The facility, Oral hy indicated nursing st with mouth care even needed. Care Plans policy (n residents would have furnished to the res practicable physica	<ul> <li>7:53 a.m. to 9:50 a.m. R15 it and finish her breakfast eakfast, R15 was assisted to y area and situated at one of his time, R15 was not offered l care.</li> <li>6 p.m. NA-A verified she did es to R15 during morning he breakfast meal. NA-A utilized swabs and mouthwash th and she should have done</li> <li>7 p.m. RN-A stated R15's oral been provided as R15 was on uth got dry.</li> <li>0 p.m. the DON confirmed R18 been offered mouth care</li> </ul>	5			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00413	B. WING		11/	25/2015
AME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY,	STATE, ZIP CODE		
ENEDIC	TINE CARE COMMU	NITY	I STREET WE N 56510	ST		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	ge 26	2 920			
	The director of nurs review and revise p to ensuring incontin for each individual nursing or designed educate staff and d	THOD OF CORRECTION: sing (DON) or designee could policies and procedures relate hence and oral care is provide resident . The director of e could develop a system to evelop a monitoring system to by iding care as directed by the	d d			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one	9			
21375	MN Rule 4658.0800 Program	3 Subp. 1 Infection Control;	21375			1/31/16
	home must establis	on control program. A nursing th and maintain an infection signed to provide a safe and nt.				
	by: Based on observati review, the facility f hand washing tech	ent is not met as evidenced on, interview and document ailed to ensure appropriate hique was performed during 2 residents (R5, R13) essing change.		Corrected		
	Findings include:					
	staff member failed	o receive wound care and the to perform appropriate hand provision of the treatment.				
	On 11/25/15, at 7:5	4 a m_registered nurse				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			- (X3) DATE SURVEY COMPLETED	
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BENEDIO	CTINE CARE COMMU	JNITY 201 9TH ADA, MN	STREET WES	т		
(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) COMPLET DATE
21375	Continued From pa	age 27	21375			
	was seated in a wh removed R5's foan the transparent dre left heel. RN-A wa removed the old dr observed to be a th was not draining. be 2.0 centimeters room to gather add approached the me additional dressing observed to wash h room. RN-A then r betadine solution to wound with the old observed to wear g RN-A then applied foam boot. At 8:00	red to approach R5 while he neelchair in his room. RN-A n boot, sock and peeled back essing covering a wound on the s not wearing gloves when she ressing. The wound was nick black scab (eschar) and RN-A measured the wound to (cm) by 1.3 cm. RN-A left the ditional dressing supplies. She edication nurse and asked for supplies. RN-A was not ner hands prior to leaving the returned to the room, applied a to the wound and covered the dressing. RN-A was not gloves during the procedure. R5's sock and replaced the 0 a.m. RN-A opened the door, valked to the neighborhood shed her hands.	•			
	not worn gloves du had she washed he	05 a.m. RN-A verified she had ring the dressing change nor er hands during the procedure. s should have been worn during				
	staff member failed	to receive wound care and the d to perform appropriate hand provision of the treatment.	)			
	11/25/15, identified anxiety, chronic no dementia, heart fai	rder Report dated 10/25/15 - R13's diagnoses as anemia, n-pressure ulcer to calf, lure and hypertension. In ssing to the non-pressure				

00413     B. WING	STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
AME OF PROVIDER OR SUPPLIER     STREET ADDRESS. CITY, STATE, ZIP CODE       BENEDICTINE CARE COMMUNITY     Z01 9TH STREET WEST ADA, NN 56510       (M, ID TAG     SUMMARY STATEMENT OF DEFICIENCIES IEACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DEDITIFYING MECHANATON)     ID PROVIDERS PLAN OF CORRECTION SHOLD BE CROSS REFERENCE TO THE APPROPRIATE DEFICIENCY)       21375     Continued From page 28 related ulcer on the right calf was ordered to be changed twice a day.     21375       On 11/24/15, at 10:10 a.m. trained medication aide (TMA)-B completed a dressing change on R13's right calf wound. TMA-B gathered supplies and transported R13 to his room. TMA-B washed his hands in the bathroom sink and donned a pair of gloves. R13 remained seated in his wheelchair beside his bed. TMA-B situated himself on the floor facing R13. TMA-B removed the foam boot from R13's right leg. At 10:13 a.m. registered nurse (RN)-B entered R13's room to assist TMA-B with R13's dressing change. TMA-B removed the dried bloody stained stockinet from R13's right leg. TMA-B sprayed dermal wound cleanser spray. RN-B left R13's room and retrieved a bottle of sterile water. RN-B poured the sterile water not R13's roynt and retrieved a bottle of sterile water. RN-B poured the sterile water not R13's roynt and retrieved a bottle of sterile water. RN-B poured the sterile water not R13's roynt and retrieved a bottle of sterile water. RN-B bourd diceanser spray. RN-B left R13's room and retrieved a bottle of sterile water. RN-B poured the sterile water not R13's roynt and retrieved a bottle of sterile water. RN-B poured the sterile water not R13's wound and removed the remaining 4x4 gauze dressings and placed them in a nearby garbage. The 4x4 dressings were saturated with bloody, serrosanguineous (yellowish drainage with small				A. BUILDING.			
BENEDICTINE CARE COMMUNITY         201 9TH STREET WEST ADA, NN 56510           IMA ID PRETX TAG         SUMMARY STATEMENT OF DEFUICENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         IP PRETX TAG         PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRETX TAG         IP PRETX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE         OWN DATE           21375         Continued From page 28 related ulcer on the right calf was ordered to be changed twice a day.         21375           On 11/24/15, at 10:10 a.m. trained medication aide (TMA)-B completed a dressing change on R13's right calf wound. TMA-B gathered supplies and transported R13 to his room. TMA-B washed his hands in the bathroom sink and donned a pair of gloves. R13 remained seated in his wheelchair beside his bed. TMA-B situated himself on the floor facing R13. TMA-B removed the foam boot from R13's right leg. At 10:13 a.m. registered nurse (RN)-B entered R13's room to assist TMA-B wound and removed the achiered 4 inch by 4 inch (4x4) gauze dressings from the wound. TMA-B ran out of the dermal wound cleanser spray. RN-B left R13's room and retrieved a bottle of sterile water. RN-B poured the sterile water onto R13's wound and removed the remaining 4x4 gauze dressings and placed them in a nearby garbage. The 4x4 dressings were saturated with bloody, serosanguineous (vellowish drainage with small			00413	B. WING		11/	25/2015
BENEDICTINE CARE COMMUNITY       ADA, MN 56510         (M) ID       SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG       ID       PROVIDERS PLAN OF CORRECTION SHOLLD B (EACH DEFICIENCY MUST BE PROCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID       PREFIX TAG       PROVIDERS PLAN OF CORRECTIVE ACTION SHOLLD B (EACH DEFICIENCY MUST BE PROCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID       PREFIX TAG       PROVIDERS PLAN OF CORRECTIVE ACTION SHOLLD BE CROSS.REFERENCED TO THE APPROPRIATE DEFICIENCY)       ID         21375       Continued From page 28 related uicer on the right calf was ordered to be changed twice a day.       21375       ID       ID <td>NAME OF I</td> <td>PROVIDER OR SUPPLIER</td> <td>STREET AD</td> <td>DRESS, CITY, S</td> <td>TATE, ZIP CODE</td> <td></td> <td></td>	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
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amounts of blood) drainage. Without changing gloves and/or washing his hands, TMA-B opened three sterile packages of 4x4 gauze dressings and applied them to R13's wound. TMA-B then placed an ABD dressing (a sterile highly absorbent dressing) over the 4x4 gauze dressings. While RN-B held the ABD dressing in place, TMA-B placed a new stockinet over the calf wound dressings. TMA-B removed his		aide (TMA)-B comp R13's right calf wou and transported R1 his hands in the bai of gloves. R13 rem beside his bed. TM floor facing R13. T from R13's right leg nurse (RN)-B enter TMA-B with R13's of removed the dried R13's right leg. TM cleanser on the wo 4 inch by 4 inch (4x wound. TMA-B ran cleanser spray. RN retrieved a bottle of the sterile water inte "dermal wound cleas spray the sterile water placed them in a ne dressings were satu serosanguineous () amounts of blood) of gloves and/or wash three sterile packag and applied them to placed an ABD dres absorbent dressing dressings. While F place, TMA-B place	bleted a dressing change on and. TMA-B gathered supplies 3 to his room. TMA-B washed throom sink and donned a pair hained seated in his wheelchair MA-B situated himself on the MA-B removed the foam boot g. At 10:13 a.m. registered ed R13's room to assist dressing change. TMA-B bloody stained stockinet from IA-B sprayed dermal wound und and removed the adhered (4) gauze dressings from the nout of the dermal wound -B left R13's room and 5 sterile water. RN-B poured to the spray bottled labeled anser." TMA-B continued to ther onto R13's wound and ning 4x4 gauze dressings and earby garbage. The 4x4 urated with bloody, vellowish drainage with small drainage. Without changing ing his hands, TMA-B opened ges of 4x4 gauze dressings to R13's wound. TMA-B then ssing (a sterile highly ) over the 4x4 gauze RN-B held the ABD dressing in ed a new stockinet over the				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			B. WING			
		00413			11/2	25/2015
NAME OF I	PROVIDER OR SUPPLIER		NDDRESS, CITY, S			
BENEDI	CTINE CARE COMMU	INITY	STREET WES N 56510	1		
(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) COMPLET DATE
21375	Continued From pa	age 29	21375			
	during R13's dress removed his gloves following the remov application of the c stated "he should h should have remov hands following the dressings and TMA	:25 a.m. TMA-B confirmed ing change he had not s nor washed his hands val of the soiled dressings and lean new dressings. TMA-B have." RN-B confirmed TMA-B ved his gloves and washed his e removal of the soiled A-B should have also put on a prior to the application of the	3			
		8 a.m. director of nursing the expected staff to follow the Dressing policy.				
	wash their hands a may be contaminat infectious. Also to	ey (undated) directed staff to fter contact with material whic ted and/or potentially wash hands after a source of s membranes, and removal of				
	staff to wash and d conducting a dress should be donned; removed; the glove dressing and disca should be washed opened; then hand a clean pair of glov be cleansed and ne gloves should be re	gs policy dated 2/14, directed lry their hands prior to sing change; clean gloves then the soiled dressings a should be pulled over the rded into a plastic bag; hands and dried thoroughly; supplies s washed and dried again and res donned; the wound should ew clean dressings applied; emoved and hands washed completion of the dressing	i I			

Minneso	ta Department of He	alth				
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		00413	B. WING		11/2	5/2015
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BENEDIC	CTINE CARE COMMU	NITY 201 9TH S ADA, MN	56510	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 30	21375			
	change.					
	The director of nurs infection control pra educate staff. The designee, could con delivery of care to e	HOD OF CORRECTION: sing or designee, could review actices during wound care and director of nursing or nduct random audits of the ensure appropriate care and nented in order to reduce the				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21510	MN Rule 4658.1200 SpecializedRehabil	) Subp. 2 A.B. itative Services; Provision	21510			1/31/16
	rehabilitative servic resident's compreh- nursing home must A. provide the req required services fr according to part 46 This MN Requirement by:	uired services; or obtain the om an outside source 558.0075. ent is not met as evidenced		Corrected		
	review, the facility fa Preadmission Scree (PASRR) was comp	on, interview and document ailed to ensure a level II ening and Resident Review bleted for 1 of 1 resident (R58) with intellectual disabilities.		Corrected		
Alara i T	Findings include:					
linnoaata D	epartment of Health					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
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21510	Continued From pa	age 31	21510			
	Sanford Medical C diagnoses included disorder characteri and chronic feeling delayed and anxiet home prior to her a R58's Progress not	sult note dated 10/27/15, fro enter Fargo indicated R58's d Prader-Willi (rare genetic zed by cognitive disabilities of hunger), developmental y. R58 had resided in a gro admission to the hospital. te dated 11/6/15, indicated I required extensive assist wit	ly pup R58			
	R58's The Pre-Adr (PAS/OBRA Level Level II Developme final review of the r	nission Screening Assessm I) dated 11/5/15, indicated a ental Disability Evaluation ar need for specialized service acing a check mark next to	เ nd s			
	11/20/15, had beer progress notes by (LSW)-A. This not been left with Norm	54 p.m. a late entry for entered into R58's residen licensed social worker e indicated a message had nan county social services ate on the level II PASRR	t			
		0 p.m. R58 was observed chair yoga activity in the				
	common area in he	02 p.m. R58 was seated in t er wheelchair where she ate ed with staff and other				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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21510	Continued From pa	ge 32	21510			
	11/23/15, had been progress notes by L	3 a.m. a late entry for entered into R58's resident SW-A indicating another left with NCSS regarding the or R58.				
	indicated LSW-A hand NCSS representative PASRR screening h	e dated 11/24/15, at 9:53 a.m. ad contacted NCSS and the ve had confirmed the level II nadn't been completed and neck with her supervisor.				
		30 a.m. R58 was observed in epartment participating in a				
	R58's level II PASR completed. LSW-A had ten days to con stated the county re there had been a m level II PASRR scree missed. At this time	3 a.m. LSW-A confirmed R screening had not been stated she thought the county nplete this screening. LSW-A epresentative had informed her hiscommunication and the eening for R58 had been e, LSW-A was unaware of y would be completed.				
	the dining room eat she used to have a development cente labels on papers ar	0 a.m. R58 was observed in ing her breakfast. R58 stated job at the occupational r (ODC) where she placed ad also put papers in a R58 stated she missed her				

STATEMEN	Ita Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUP IDENTIFICATION			CONSTRUCTION		E SURVEY PLETED
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21510	Continued From pa	ige 33		21510			
	The Admission Pre Mental Retardation indicated a nursing resident with an inte disability until author admission that the service provided by the individual require SUGGESTED MET The director of nurs review and revise p to ensuring PASAR newly admitted resi or designee could of staff and develop a newly admitted resi	or Mental Illness facility was not to ellectual or develo prity had determine individual required the facility and wi red specialized se THOD OF CORRE sing (DON) or des policies and proceed screenings are co idents. The direct develop a system	dated 4/12, admit any pmental ed prior to I that level of hether or not rvices. CTION: ignee could dures related ompleted for or of nursing to educate n to ensure				
	TIME PERIOD FOI (21) days.	R CORRECTION:	Twenty-one				
21530	MN Rule 4658.131	0 A.B.C Drug Reg	imen Review	21530			1/31/16
	A. The drug regim reviewed at least m currently licensed b This review must b Appendix N of the S Surveyor Procedur Requirements in Lo the Department of Health Care Financ This standard is in available through th system. It is not su	nonthly by a pharm by the Board of Ph e done in accorda State Operations N es for Pharmaceu ong-Term Care, p Health and Human sing Administration corporated by refe the Minitex interlib	acist armacy. nce with Manual, tical Service ublished by Services, a, April 1992. erence. It is rary loan				

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		00413	B. WING		11/2	25/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	JNITY 201 9TH S ADA, MN	STREET WE	ST		
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 34	21530			
	irregularities to the and the attending p must be acted upo physician visit, or s pharmacist. For pu upon" means the a report and the sign of nursing services C. If the attend with the pharmacis not provide adequa pharmacist believe being adversely aff refer the matter to if the medical direct physician. If the m the attending physi justification for the physician does not must be referred for assessment and as by part 4658.0070. the medical direct must refer the matter	acist must report any director of nursing services obysician, and these reports n by the time of the next sooner, if indicated by the urposes of this part, "acted acceptance or rejection of the ing or initialing by the director and the attending physician. ding physician does not concur it's recommendation, or does ate justification, and the es the resident's quality of life is fected, the pharmacist must the medical director for review otor is not the attending edical director determines that ician does not have adequate order and if the attending change the order, the matter or review to the quality ssurance committee required If the attending physician is or, the consulting pharmacist ter directly to the quality ssurance committee.				
	by: Based on interview facility failed to ens the lack of target b pharmacological in prior to the adminis	terventions to be attempted stration of an as needed (PRN) ation for 1 of 1 resident (R49)		Corrected		

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00413	B. WING		11/2	25/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE	•	
BENEDI	CTINE CARE COMMU	INITY	H STREET WES IN 56510	т		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 35	21530			
	received hypnotic r	medications.				
	Findings include:					
	medicaiton) withou of the medication in pharmacological in	lorazepam (antianxiety it target behaviors for the use dentified nor non iterventions to be attempted stration of the medication.				
	8/31/15, indicated impairment, showe behavior towards s had received one c	Inimum Data Set (MDS) data R49 had severe cognitive ed no signs of psychosis or self or others. In addition, R4 dose of PRN antianxiety the seven day observation ssment.				
	Assessment (CAA) was at risk for side antianxiety medica identification of targ nonpharmacologic	al interventions to be to the administration of the	9			
	that included chror disease, anxiety di dementia. In addit had ordered loraze could be given PRI	rder Report dated , indicated R49 had diagnose nic obstructive pulmonary sorder, heart failure and ion, on 8/18/15, the physiciar pam 0.5 milligrams (mg) that N up to three times a day for y. However, the order had no	ı t			

TATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00413	B. WING		11/2	25/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
BENEDIC	CTINE CARE COMMU	INITY	STREET WES	T		
(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) COMPLET DATE
21530	Continued From pa	age 36	21530			
	identified specific ta the PRN lorazepan	arget behaviors for the use of n.				
	area for psychotrop interventions direct effects of the psych physician and phar per guidelines for g care plan lacked id for the use of the F nonpharmacologic	entified on 8/18/15, a problem bic medication use. The ted staff to monitor for side notropic medication and for the macist review to be conducted gradual dose reduction. R49's lentification of target behaviors PRN lorazepam and al interventions to be the administration of the tion.	k			
	medications dated mg PRN up to two section of the cons target behaviors to	nsent for psychotropic 1/17/15, listed lorazepam 0.5 times a day for anxiety. The sent form which requested that be noted in specific terms, n of target behaviors for the am.				
	dated 9/1/15 - 11/2 received lorazepan 9/24/15, 10/5/15, 1 lorazepam 0.5 mg variety of reasons a self-transferring, re R49's medical reco regards to nonphar attempted prior to t	ations Administration History 5/15, indicated R49 had n 0.5 mg on 9/13/15, 9/14/15, 0/19/15, and 10/29/15. The had been administered for a such as picking her nose, estlessness, and yelling out. ord lacked documentation with rmacological interventions the administration of the /14, 9/14/15, and 10/29/15.				
nesota D	Review of the phar	macists monthly medication				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00440	B. WING			
	PROVIDER OR SUPPLIER	00413	ADDRESS, CITY, S		11/2	25/2015
		201 9TH	STREET WES			
SENEDIC	CTINE CARE COMMU	ADA, M	N 56510			
(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) COMPLET DATE
21530	Continued From pa	age 37	21530			
	mention of the nee behaviors and non	m 8/23/15 - 11/5/15, lacked of for the identification of targe pharmacological interventions f R49's PRN lorazepam.				
	(RN)-B confirmed nonpharmacologic specifically identifie for the utilization of RN-B stated the lic usually developed care plan which we	43 p.m. registered nurse target behaviors and al interventions had not been ed or consistently documented f the PRN lorazepam for R49. censed social worker (LSW)-A the psychotropic portion of the buld list the target behaviors logical interventions.				
	pharmacist (CP) co nonpharmacologic been identified and PRN use of the lor tried to make sure	10 p.m. the consulting onfirmed target behaviors and al interventions should have d consistently utilized for R49's azepam. The CP stated she these were identified and rt of the monthly pharmacy reviews.				
	target behaviors an interventions had r	30 a.m. LSW-A confirmed nd nonpharmacological not been specifically identified use of the lorazepam.				
		evelopment and target behaviors and al interventions was provided.				
		l lacked sleep pattern continued use of a hypnotic				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	MDED.	PLE CONSTRUCTION G:		E SURVEY PLETED
		00413	B. WING		11//	25/2015
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY	, STATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	ΝΙΤΥ	201 9TH STREET WI ADA, MN 56510	EST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	ge 38	21530			
	was diagnosed with insomnia. The MDS cognition and requi	dated 8/23/15, indic diabetes, a stroke a also indicated R5 h red extensive assista ers and was unable t	and ad intact ance with			
	started on 11/28/14 medication). The c was decreased to 1 The orders also dire	ians orders included , for Zaleplon (hypno rders indicated the n 0 mg at bedtime on ected staff to chart R and pattern if it had in	nedication 11/6/15. 5's			
		d 12/22/14, directed for insomnia and m				
	had been evaluated Zaleplon was decre	e dated 11/6/15, indic d by the psychiatrist a eased to 10 mg at be ease in sleep apnea.	and the			
	indicated R5 had no frequently up throug displayed irritability	c notes dated 11/12/ ot been sleeping well ghout the night. R5 h towards the staff and rs. A sleep study wa	and was nad d			
		lacked any indicatior and / or documentation				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00413	B. WING		11/25/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
BENEDIO	CTINE CARE COMMU	INITY	STREET WES N 56510	Т		
(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) COMPLET DATE
21530	Continued From pa	age 39	21530			
	difficulty sleeping a scheduled for Dece nurses were to be since the hypnotic reduced on 11/6/15 progress notes and	24 p.m. RN-A stated R5 had and a sleep study had been ember 2015. She stated the documenting his sleep pattern medication had just been 5. RN-A then reviewed R5's d confirmed the facility had not b's sleep pattern since his ad been changed.				
	went to bed around	50 p.m. R5 stated he routinely 6 6:00 p.m. He stated he only took the medications.				
	indicated R5 was rebedtime on 5/7/15. 11/5/15, indicated t and the staff were However, the clinic	macist Progress Notes eceiving Zaleplon 15 mg at The pharmacist note dated he Zaleplon had been reduced to continue to monitor sleep. al record lacked ated to sleep pattern	Ł			
	identified the Zalep staff were to monite However, the CP c the lack of sleep pa	0 p.m. the CP stated she had lon had been decreased and or R5's sleep pattern. onfirmed she had not identified attern monitoring and had not o monitor R5's sleep pattern.	d			
	Review policy direct to review the medic resident monthly.	nacist Medication Regimen sted the consultant pharmacist cation regimen for each The policy did not direct the rre the facility was monitoring				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY IPLETED
		00413	B. WING		11/	25/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	NITY 201 9TH ADA, MN	STREET WEST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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
21530	Continued From pa each client for the c medication.	ge 40 continued need for the	21530			
	The administrator, of consulting pharmac policies and proced medication usage. I educated as necess pharmacist's review with the pharmacist	HOD OF CORRECTION: director of nursing (DON) and sist could review and revise ures for proper monitoring of Nursing staff could be sary to the importance of the <i>x</i> . The DON or designee, along to could audit medication r basis to ensure compliance.	3			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary al	21535			1/31/16
	must be free from u unnecessary drug is A. in excessive therapy; B. for excessive C. without adec D. in the preserve which indicate the c discontinued. In addition to the d part 4658.1310, the with provisions in th Code of Federal Ree 483.25 (1) found in Operations Manual Long-Term Care Fa	al. A resident's drug regimen innecessary drugs. An s any drug when used: dose, including duplicate drug e duration; quate indications for its use; or nce of adverse consequences lose should be reduced or rug regimen review required in e nursing home must comply ie Interpretive Guidelines for egulations, title 42, section Appendix P of the State , Guidance to Surveyors for icilities, published by the lth and Human Services,				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	- (X3) DATE SURVEY COMPLETED	
		00413	B. WING		11/2	25/2015
NAME OF	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	INITY	TH STREET WE MN 56510	ST		
(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 THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 41	21535			
	This standard is in available through the	cing Administration, April 19 corporated by reference. It i he Minitex interlibrary loan ate Law Library. It is not change.				
	by: Based on observat review the facility fa behaviors and iden pharmacological in (R49) who received anti-anxiety medica failed to monitor th hypnotic medicatio received a hypnotic	tion, interview and document ailed to identify target ntify and implement non terventions for 1 of 1 reside d an as needed (PRN) ation. In addition, the facility e sleep pattern for the use of n for 1 of 1 resident (R5) wh c, had a dose change and tion related to the effectivent	t nt , of	Corrected		
	Findings include:					
	medication) and ta nonpharmacologic	lorazepam (antianxiety rget behaviors and al interventions had not been tently implemented.	n			
	8/31/15, indicated impairment, showe behavior towards s had received one c	linimum Data Set dated R49 had severe cognitive ed no signs of psychosis or self or others. In addition, R4 dose of PRN antianxiety the seven day observation ssment.	49			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00413	B. WING		11/	11/25/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE			
BENEDIC	CTINE CARE COMMU	INITY	I STREET WES N 56510	т			
(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	TION SHOULD BE	(X5) COMPLET DATE	
21535	Continued From pa	age 42	21535				
	Assessment (CAA) was at risk for side antianxiety medica identification of targ nonpharmacologica	al interventions to be to the administration of the	)				
	area for psychotrop interventions direct effects of the psych physician and phar per guidelines for g care plan lacked id for the use of the P nonpharmacologica	entified on 8/18/15, a problem bic medication use. The red staff to monitor for side notropic medication and for the macist review to be conducted gradual dose reduction. R49's entification of target behaviors PRN lorazepam and al interventions to be the administration of the tion.	e d				
	that included chron disease, anxiety dis dementia. In additi had ordered loraze could be given PRI generalized anxiety	indicated R49 had diagnoses ic obstructive pulmonary sorder, heart failure and ion, on 8/18/15, the physician pam 0.5 milligrams (mg) that N up to three times a day for y. However, the order had not arget behaviors for the use of					
	medications dated mg PRN up to two section of the cons	nsent for psychotropic 1/17/15, listed lorazepam 0.5 times a day for anxiety. The ent form which requested that e noted in specific terms,	t				

STATEMEN	Ita Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00413	B. WING		11//	25/2015
NAME OF I	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, S	TATE, ZIP CODE		
BENEDI	CTINE CARE COMMU		9TH STREET WES A, MN 56510	ST		
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535		n of target behaviors for the	21535 e			
	dated 9/1/15 - 11/29 received lorazepam 9/24/15, 10/5/15, 10 lorazepam 0.5 mg l variety of reasons s self-transferring, re R49's medical reco regards to nonphar attempted prior to t	tions Administration Histor 5/15, indicated R49 had n 0.5 mg on 9/13/15, 9/14/ 0/19/15, and 10/29/15. Th had been administered for such as picking her nose, stlessness and yelling out. ord lacked documentation v macological interventions he administration of the /14, 9/14/15, and 10/29/15	15, le a with			
	the dining room, se	1 a.m. R49 was observed ated in her wheelchair. R4 oxygen on and eating her lently.				
	seated in a recliner	8 a.m. R49 was observed by the fireplace in the had her feet elevated, s closed.				
	(TMA)-B stated R4 when R49 attempted she wanted to get u TMA-B confirmed F nonpharmacologica attempted prior to t	0 p.m. trained medication 9 received the PRN loraze ed to self-transfer because up and go to the bathroom R49 lacked identification of al interventions to be he administration of the PI 8 stated they just would try	pam e f RN			

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00413	B. WING		11/2	11/25/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, S	TATE, ZIP CODE			
BENEDI	CTINE CARE COMMU	INITY	TH STREET WES MN 56510	Т			
(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) COMPLET DATE	
21535		age 44 I3 p.m. registered nurse	21535				
	(RN)-B confirmed t nonpharmacologic specifically identifie for the utilization of RN-B stated the lic usually developed care plan which wo	target behaviors and al interventions had not beer ed or consistently documente f the PRN lorazepam for R49 eensed social worker (LSW)- the psychotropic portion of the build list the target behaviors logical interventions.	ed 9. A				
	pharmacist (CP) st nonpharmacologic	0 p.m. the consulting ated target behaviors and al interventions should have consistently utilized for R49 azepam.	's				
	target behaviors ar	80 a.m. LSW-A confirmed nd nonpharmacological not been specifically identified of the lorazepam.	d				
		evelopment and target behaviors and al interventions was provided	J.				
		l lacked sleep pattern continued use of a hypnotic					
	was diagnosed with insomnia. The MD cognition and requi	S dated 8/23/15, indicated R h diabetes, a stroke and S also indicated R5 had intac ired extensive assistance wit fers and was unable to	ct				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00413	B. WING		11/2	11/25/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE	<b>I</b>		
BENEDI	CTINE CARE COMMU	JNITY	I STREET WES N 56510	т			
(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	
21535	Continued From pa	age 45	21535				
	ambulate.						
	started on 11/28/14 medication). The of was decreased to 11/6/15. The order	cians orders included an order 4, for Zaleplon (hypnotic orders indicated the medicatio 10 milligrams at bedtime on rs also directed staff to chart avior and pattern if it had					
		ed 12/22/14, directed staff to n for insomnia and monitor for					
	had been evaluate Zaleplon was decr	e dated 11/6/15, indicated R5 d by the psychiatrist and the eased to 10 mg at bedtime as ease in sleep apnea.	it				
	indicated R5 had n frequently up throu displayed irritability	ic notes dated 11/12/15, ot been sleeping well and was ghout the night. R5 had towards the staff and ors. A sleep study was ordere					
		l lacked any indication of sleep and / or documentation.					
	difficulty sleeping a scheduled for Deco nurses were to be	:24 p.m. RN-A stated R5 had and a sleep study had been ember 2015. She stated the documenting his sleep pattern medication had just been	1				

TATEMENT OF DEFICIENCIES (X ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			_				
		00413	B. WING		11/2	11/25/2015	
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
BENEDI	CTINE CARE COMMU	JNITY ADA, M	STREET WES	1			
(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	(X5) COMPLET DATE	
21535	Continued From pa	age 46	21535				
	progress notes / cli facility had not doc	5. RN-A then reviewed R5's inical record and confirmed the umented on R5's sleep patter on dose had been changed.	)				
	went to bed around	50 p.m. R5 stated he routinely d 6:00 p.m. He stated he only took the medications.					
	A policy regarding requested and non	medication monitoring was e was provided.					
	The director of nur- review and revise p to ensuring medica director of nursing system to educate	THOD OF CORRECTION: sing (DON) or designee could policies and procedures related ation regimen review. The or designee could develop a staff and develop a monitoring esidents are not receiving cations.					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
21695	MN Rule 4658.141 Housekeeping, Op	5 Subp. 4 Plant eration, & Maintenance	21695			1/31/16	
	provide housekeep necessary to maint comfortable interio	eeping. A nursing home must bing and maintenance services tain a clean, orderly, and r, including walls, floors, fixtures, equipment, lighting,					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00413	B. WING		11/25/2015	
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
	CTINE CARE COMMU	201 9TH	STREET WE			
BENEDI		ADA, MI	N 56510	1	1	
(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	TION SHOULD BE COMPLE	
21695	Continued From pa	age 47	21695			
	by:	ent is not met as evidenced ion and interview, the facility		Corrected		
	failed to ensure wh maintained in a cle	eelchair armrests were an, safe and sanitary conditior (R49, R56, R7) who had torn,		Conecleu		
	Findings include:					
		82 p.m. R49's right wheelchair rved very loose, wobbly.				
		3 p.m. R56's wheelchair arm ed uncovered with padding				
	seated in the whee	29 p.m. R7 was observed Ichair. R7's wheelchair arm ed torn and cracked.				
	Director (ED) obse wheelchairs and ve arm rest was missi and stated it would R56's arm rests we uncleanable paddir In addition, the ED	:45 p.m. the Environmental rved the aforementioned erified R49's right wheelchair ing screws and coming apart be fixed. The ED verified ere uncovered with exposed, ing and they would be replaced verified R7's arm rests were				
	and in need of repa be replaced. -At 1:00 p.m. the E	exposed padding, uncleanable air. The ED stated they would D stated the facility did not ce schedule specific for the	Ð			
nesota D		heelchair arm rest rather, the				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00413	B. WING	B. WING		25/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE		
BENEDI	CTINE CARE COMMU	INITY	H STREET WES IN 56510	Т		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21695	to maintenance who of repair or replace facility did not have	ige 48 directed to submit a work ord en a wheelchair was in need ment. The ED stated the a policy and procedure tenance of wheelchairs / arm				
	The director of nurs educate staff regard resident equipment designee, could coo nursing staff to con wheelchairs to ensu	THOD OF CORRECTION: sing (DON) or designee, coulding the importance reporting repair need. The DON or ordinate with maintenance and duct periodic audits of reside ure needed repairs are I or designee could forward mmittee for review.	g nd			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-on	e			
21840	MN St. Statute 144 Residents of HC Fa	.651 Subd. 12 Patients & ac.Bill of Rights	21840			1/31/16
	residents shall have based on the inform 9. Residents who r or dietary restriction likely medical or ma the refusal, with do medical record. In o incapable of unders has not been adjud legal requirements treatment, the conc	o refuse care. Competent e the right to refuse treatment nation required in subdivision refuse treatment, medication hs shall be informed of the ajor psychological results of cumentation in the individual cases where a resident is standing the circumstances be licated incompetent, or when limit the right to refuse ditions and circumstances sh d by the attending physician	n , put all			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		00413	B. WING		11/25/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	• • • •	
BENEDIO	CTINE CARE COMMU	INITY	STREET WE	ST		
		ADA, MI		PROVIDER'S PLAN OF		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE CO THE APPROPRIATE	(X5) OMPLET DATE
21840	Continued From pa	age 49	21840			
	the resident's med	ical record.				
	This MN Requirem	ent is not met as evidenced				
	by: Based on observat review the facility fa risk for pressure ul related to the risk v repositioning assis	tion, interview and document ailed to ensure a resident at Icers was provided education versus (vs) benefits of refusing tance for 1 of 1 resident (R5) Irrent stage four ulcer and		Corrected		
	Findings include:					
	8/23/15, indicated diabetes, history of the development o also indicated R5 h extensive assistant	mum Data Set (MDS) dated R5 was diagnosed with f a stroke and was at risk for f pressure ulcers. The MDS nad intact cognition, required ce with bed mobility, transfers ambulate.				
	(CAA) dated 2/20/1 the development o for assistance with of incontinence. T a history of periphe neuropathy in his le assessment directed	er Care Area Assessment 15, indicated R5 was at risk for f pressure ulcers due to need mobility, transfers and history he CAA also indicated R5 had eral artery disease, edema and ower extremities. The ed staff to utilize a pressure ion on his wheelchair and to pooties on his feet.				
		ed 3/9/15, directed staff to a diabetic shoe on the left foot				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		00413	B. WING		11/	11/25/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET	T ADDRESS, CITY, S	TATE, ZIP CODE	<b>I</b>		
BENEDI	CTINE CARE COMMU	INITY	TH STREET WES MN 56510	T			
(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	
21840	when up in the cha the left foot when in Holister heel, lift bo foot in bed and a P when in the wheeld staff to assist R5 to R5's Braden Scale pressure ulcer risk) was at moderate ris pressure ulcer.	ir and Prevalon (foam) boot n bed. R5 was to utilize a bot (formed boot) on the right revalon boot on the right foo chair. The care plan directed o reposition every two hours. (tool utilized to identify ) dated 11/17/15, indicated F sk for the development of es dated 11/6/15, indicated F atch of black eschar (thick on his left heel which	t t {5				
	R5's Progress Note	imeters (cm) by 1.5 cm. e dated 11/21/15, indicated th esent on R5's left heel.	he				
	dining room, seated R5 was continuous until 10:30 a.m. -At 7:31 a.m. R5 w his room where he -At 8:20 a.m. nursin reposition R5 but h -At 9:22 a.m. NA-D refused assistance -At 9:50 a.m. NA-E assistance during t allowed the day shi had arrived at the f -At 10:00 a.m. NA-	Ity observed from 7:30 a.m. heeled from the dining room turned on the television. ng assistant (NA)-D offered t e refused. Preturned to the room and R Stated R5 frequently refuse he day. She stated R5 had ift staff to assist him since th	to to 5 ed not				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 11/25/2015	
		00413					
AME OF I	PROVIDER OR SUPPLIER		ET ADDRESS, CITY, S	ADDRESS, CITY, STATE, ZIP CODE			
BENEDI	CTINE CARE COMMU	INITY	TH STREET WES MN 56510	T			
(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) COMPLET DATE	
21840	Continued From page 51		21840				
	into the wheelchair not accepted assis that time. -At 10:15 a.m. R5 w with a ceiling lift (fu ceiling) from the wl wheelchair was ob- pressure redistribu was observed pink were observed to b Prevalon boots. No the wheelchair for g	he night staff had assisted F before 6:00 a.m. and he had tance with repositioning sin was observed to be transfer all body lift attached to the heelchair to the toilet. R5's served equipped with a tion cushion. R5's buttocks with the skin intact. R5's fe be covered with bilateral A-D confirmed R5 had been greater than 4 hours and 15 of used assistance with	ad ce rred eet				
	repositioning / refu	nical record lacked icating the risk vs benefits of sal to repositioned in ssure ulcer prevention.	of				
	(RN)-A stated R5's area of concern on was soft and had a it was intact. She s Holister boots were boots were implem a long history of re- members and she	:40 a.m. registered nurse left heel was noted to have a 10/27/15. She stated the h in area of 1.8 cm x 2.1 cm k stated at that time, R5's e removed and the Prevalor hented. She explained R5 h fusing care from staff had talked to him the past had not documented the	neel put				
	stated staff should benefits of refusal	0 p.m. the director of nursin have discussed the risk vs of care with R5 and concerns in the clinical rec					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED 11/25/2015	
		00413			11/		
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, S	TATE, ZIP CODE		11/23/2013	
BENEDI	CTINE CARE COMMU	INITY	I STREET WES N 56510	т			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CC PREFIX (EACH CORRECTIVE ACTIO TAG CROSS-REFERENCED TO THI DEFICIENCY)		TION SHOULD BE	N SHOULD BE COMPLE E APPROPRIATE DATE	
21840	Continued From pa	age 52	21840				
	On 11/24/15, at 3:50 p.m. R5 stated he could not recall any staff members talking to him about the importance of repositioning or pressure ulcer prevention.						
	On 11/25/15, at 7:55 a.m. RN-A removed R5's lef Prevalon boot and dressing from the left heel. R5 was observed to have a stage four (full thickness tissue loss in which actual depth of the ulcer is completely obscured by eschar (black) in the wound bed) black area on the left heel which measured 2.0 cm by 1.3 cm.		5				
	indicated any time the staff were to do how the resident w the treatment and t receiving the treatment refusals and altern	atment policy dated 2/2014, a resident refused treatment, ocument the residents refusal, as informed of the purpose of the consequences of not nent, physician notification of ative approaches attempted to dent to comply with treatment.					
	The director of nur- review and revise related to resident's after having been e The DON could de ensure ongoing co	ETHOD FOR CORRECTION: sing (DON) or designee could policies and procedures s rights to refuse treatment educated to potential risks. velop monitoring systems to mpliance and report the lity Assurance Committee.					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty one					