MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

Certified Mail # 7013 3020 0001 8869 0763

February 26, 2016

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

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

Dear Mr. Hoemberg:

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

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

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

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

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

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

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

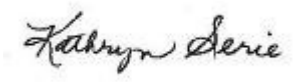
The facility's Turning and Repositioning policy was also reviewed and indicated, "if a resident's skin is impaired related to a pressure ulcer, and once the area had healed, the resident would remain on a turning and repositioning shchedule of one hour for six months." The plan of care and staff interview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

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

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

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

Sincerely,



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

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 6OS7

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2008**

6. DATE OF SURVEY **01/26/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE — Date :
Jana Bromenshenkel, HFE NE II — 02/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 02/05/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS
Posted 01/11/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 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,

Kamala Fiske-Downing

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

Minnesota Department of Health

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,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245502 Y1	A. Building B. Wing Y2	1/26/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0155	Correction	ID Prefix F0279	Correction	ID Prefix F0282	Correction
Reg. # 483.10(b)(4)	Completed	Reg. # 483.20(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	Correction	ID Prefix F0314	Correction
Reg. # 483.25	Completed	Reg. # 483.25(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	Correction	ID Prefix F0428	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.45(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
Reg. # 483.65	Completed	Reg. # 483.70(h)	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 STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	LB/kfd	2/5/2016	32601	01/26/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/25/2015

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

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

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,

Kamala Fiske-Downing

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00413 Y1	A. Building B. Wing Y2	1/26/2016 Y3

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

This report is completed by a 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20560	Correction	ID Prefix 20565	Correction	ID Prefix 20830	Correction
Reg. # MN Rule 4658.0405 Subp. 2	Completed	Reg. # MN Rule 4658.0405 Subp. 3	Completed	Reg. # MN Rule 4658.0520 Subp. 1	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 4658.0525 Subp. 3	Completed	Reg. # MN Rule 4658.0525 Subp. 6 B	Completed	Reg. # MN Rule 4658.0800 Subp. 1	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 4658.1200 Subp. 2 A.B.	Completed	Reg. # MN Rule 4658.1310 A.B.C	Completed	Reg. # MN Rule4658.1315 Subp.1 ABCD	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 4658.1415 Subp. 4	Completed	Reg. # MN St. Statute 144.651 Subd. 12	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 STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	LB/kfd	2/5/2016	32601	01/26/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/25/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 6OS7

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245502**

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2008**

6. DATE OF SURVEY **11/25/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Rebecca Haberle, HFE NEII 12/21/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/08/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS
Posted 01/11/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

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:

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

<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.

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 155		1/4/16

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

Electronically Signed | 12/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a resident at risk for pressure ulcers was provided education related to the risk versus (vs) benefits of refusing repositioning assistance for 1 of 1 resident (R5) observed with a current stage four ulcer and refused repositioning assistance. Findings include: R5's quarterly Minimum Data Set (MDS) dated 8/23/15, indicated R5 was diagnosed with diabetes, history of a stroke and was at risk for the development of pressure ulcers. The MDS also indicated R5 had intact cognition, required extensive assistance with bed mobility, transfers and was unable to ambulate. R5's Pressure Ulcer Care Area Assessment (CAA) dated 2/20/15, indicated R5 was at risk for the development of pressure ulcers due to need for assistance with mobility, transfers and history of incontinence. The CAA also indicated R5 had a history of peripheral artery disease, edema and neuropathy in his lower extremities. The assessment directed staff to utilize a pressure redistribution cushion on his wheelchair and to utilize specialized booties on his feet. R5's care plan dated 3/9/15, directed staff to ensure R5 utilized a diabetic shoe on the left foot when up in the chair and Prevalon (foam) boot on	F 155	R5 will receive education that is properly documented of risk vs. benefit education so he has full scope of what can happen if he is not properly repositioned. All residents that refuse scheduled repositioning will receive education that is properly documented of risk vs. benefit of being properly positioned. DON/designee will ensure that CNA staff will inform Charge Nurse of residents that are refusing proper cares. Charge Nurse will enter a progress note of refusal of care so that any further residents that refuse care will receive education of risk vs. benefits to follow proper plan of care. Care plans will be adjusted as changes are made. Staff will be educated at monthly staff meeting on 12-16-15. DON/designee will perform daily audits of progress notes and CNA repositioning log/toileting log to ensure that resident□s that refuse plan of care are passed onto DON/designee to educate them. Audits will be reviewed at Quality Council on 01/20/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 2	F 155		

the left foot when in bed. R5 was to utilize a Holister heel, lift boot (formed boot) on the right foot in bed and a Prevalon boot on the right foot when in the wheelchair. The care plan directed staff to assist R5 to reposition every two hours.

R5's Braden Scale (tool utilized to identify pressure ulcer risk) dated 11/17/15, indicated R5 was at moderate risk for the development of pressure ulcer.

R5's Progress Notes dated 11/6/15, indicated R5 had developed a patch of black eschar (thick scab/dead tissue) on his left heel which measured 2.1 centimeters (cm) by 1.5 cm.

R5's Progress Note dated 11/21/15, indicated the wound was still present on R5's left heel.

On 11/24/15, at 7:15 a.m. R5 was observed in the dining room, seated in a wheelchair.
R5 was continuously observed from 7:30 a.m. until 10:30 a.m.
-At 7:31 a.m. R5 wheeled from the dining room to his room where he turned on the television.
-At 8:20 a.m. nursing assistant (NA)-D offered to reposition R5 but he refused.
-At 9:22 a.m. NA-D returned to the room and R5 refused assistance.
-At 9:50 a.m. NA-E stated R5 frequently refused assistance during the day. She stated R5 had not allowed the day shift staff to assist him since they had arrived at the facility at 6:00 a.m.
-At 10:00 a.m. NA-D stated she had been in to visit R5 twice and he had refused cares each

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 3 time. She stated the night staff had assisted R5 into the wheelchair before 6:00 a.m. and he had not accepted assistance with repositioning since that time. -At 10:15 a.m. R5 was observed to be transferred with a ceiling lift (full body lift attached to the ceiling) from the wheelchair to the toilet. R5's wheelchair was observed equipped with a pressure redistribution cushion. R5's buttocks was observed pink with the skin intact. R5's feet were observed to be covered with bilateral Prevalon boots. NA-D confirmed R5 had been in the wheelchair for greater than 4 hours and 15 minutes and had refused assistance with repositioning. Review of R5's clinical record lacked documentation indicating the risk vs benefits of repositioning / refusal to repositioned in relationship to pressure ulcer prevention. On 11/24/15, at 12:40 a.m. registered nurse (RN)-A stated R5's left heel was noted to have an area of concern on 10/27/15. She stated the heel was soft and had an area of 1.8 cm x 2.1 cm but it was intact. She stated at that time, R5's Hollister boots were removed and the Prevalon boots were implemented. She explained R5 had a long history of refusing care from staff members and she had talked to him the past about refusals but had not documented the identified concern. On 11/24/15, at 3:40 p.m. the director of nursing stated staff should have discussed the risk vs benefits of refusal of care with R5 and	F 155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 4 documented those concerns in the clinical record. 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 left 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. The Refusal of Treatment policy dated 2/2014, indicated any time a resident refused treatment, the staff were to document the residents refusal, how the resident was informed of the purpose of the treatment and the consequences of not receiving the treatment, physician notification of refusals and alternative approaches attempted to encourage the resident to comply with treatment.	F 155		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279		1/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 5 assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to develop a comprehensive behavior care plan which included target behaviors and nonpharmacological interventions for 1 of 1 resident (R49) who received an as needed (PRN) anti-anxiety medication. Findings include: R49's care plan identified on 8/18/15, a problem area for psychotropic medication use. The interventions directed staff to monitor for side effects of the psychotropic medication and for the physician and pharmacist review to be conducted per guidelines for gradual dose reduction. R49's care plan lacked identification of target behaviors for the use of the PRN lorazepam and nonpharmacological interventions to be attempted prior to the administration of the antianxiety medication.	F 279	Target Behaviors and non-pharmacological interventions specific to the resident have been added to R49 care plan to alert med nurse when it is appropriate to give a PRN psychotropic medication. A review of all residents will be conducted and completed identifying all residents that have a PRN psychotropic medication and those that have a behavior section of the care plan. Targeted behaviors will be added to the psychotropic section of the care plan and the behavior & mood sections of the care plan will be reviewed and edited to ensure resident specific non-pharmacological interventions are in place and available for staff to use. Staff was educated on December 16th 2015 at the staff meeting on where to find resident specific targeted behaviors and non-pharmacological interventions to try prior to administrating a medication. An audit will be conducted to determine if resident specific target behaviors are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 6 R49's Physician Order Report dated 10/25/15-11/25/15, indicated R49 had diagnoses that included chronic obstructive pulmonary disease, anxiety disorder, heart failure and dementia. In addition, on 8/18/15, the physician had ordered lorazepam 0.5 milligrams (mg) that could be given PRN up to three times a day for generalized anxiety. However, the order had not identified specific target behaviors for the use of the PRN lorazepam. R49's PRN Medications Administration History dated 9/1/15 - 11/25/15, indicated R49 had received lorazepam 0.5 mg on 9/13/15, 9/14/15, 9/24/15, 10/5/15, 10/19/15, and 10/29/15. The lorazepam 0.5 mg had been administered for a variety of reasons such as picking her nose, self-transferring, restlessness and yelling out. R49's medical record lacked documentation with regards to nonpharmacological interventions attempted prior to the administration of the lorazepam on 9/13/14, 9/14/15, and 10/29/15. On 11/24/15, at 3:43 p.m. registered nurse (RN)-B confirmed target behaviors and nonpharmacological interventions had not been specifically identified or consistently documented for the utilization of the PRN lorazepam for R49. RN-B stated the licensed social worker (LSW)-A usually developed the psychotropic portion of the care plan which would list the target behaviors and nonpharmacological interventions. On 11/25/15, at 8:30 a.m. LSW-A confirmed target behaviors and nonpharmacological interventions had not been specifically identified	F 279	listed in the psychotropic section of the care plan, if non pharmaceutical interventions are listed under the care plan addressing the behavior and the psychotropic review team will meet monthly to review care plans for PRN psychotropic medication to ensure compliance. Audits will be brought to Quality Council on 1/20/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 7 on R49's care plan for the PRN use of the lorazepam. Care Plan policy (undated) indicated all residents would have a comprehensive care plan that included measurable objectives to meet the resident's medical, mental and psychosocial needs. The care plan would describe the services that would be furnished so the resident ' s highest practicable physical, mental and psychosocial well-being would be attained and maintained.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide every two hour turning and repositioning assistance as directed by the care plan for 1 of 3 residents (R13) identified at risk for pressure ulcers. The facility failed to provide incontinence cares as directed by the care plan for 1 of 3 residents (R3) who required assistance with incontinence cares and 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:	F 282	R13 will receive timely turning and repositioning. R3 will receive timely incontinence cares and R15 will receive oral care per the resident plan of care. DON/designee will ensure that all residents receive turning and repositioning, incontinent care and oral care per their plan of care by auditing these daily. Staff will receive just in time training up to disciplinary action if the plan of care is not being followed. Staff will be educated at the monthly staff meeting on 12/16/15. Audits will be reviewed at Quality Council on 1/20/16.	1/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 8	F 282		

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 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 bottom and applied a clean brief.
-At 8:15 a.m. NA-B transferred R13 from the bed to R13's wheelchair which had a pressure relieving cushion in its seat.
-At 8:38 a.m. NA-B transported R13 out into the common area and positioned R13's wheelchair near the fire place. R13 had a blue foam boot on his right foot.
-At 9:10 a.m. R13 complained of being cold and trained medication aide (TMA)-B retrieved another blanket and placed over R13's shoulders. R13 remained seated in his wheelchair in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 9 common area, until 10:10 a.m. when TMA-B transported R13 back to his room. -At 10:13 a.m. TMA-B with the assistance of registered nurse (RN)-B completed a dressing change to R13's right lower leg. R13 remained seated in the wheelchair during the dressing change. - At 10:40 a.m. (two hours and 25 minutes since R13 had last been repositioned) TMA-B and RN-B transferred R13 from the wheelchair back to R13's bed. RN-B removed R13's dry brief and confirmed R13 had two open areas on his buttocks and R13's bottom was reddened. TMA-B retrieved a measuring tape and RN-B measured both open areas. RN-B verified the pressure ulcer on the right side was 0.7 cm in length x 0.6 cm in width and the pressure ulcer on the left measured 0.7 cm x 0.8 cm. RN-B confirmed both of these pressure ulcers where new. On 11/24/15, at 1:50 p.m. RN-B and the director of nursing (DON) confirmed it was their expectation for staff to follow R13's care plan with regards to R13's every two hours turning and repositioning schedule and other pressure ulcer prevention interventions. On 11/24/15, at 9:08 a.m. NA-B stated R13 should be repositioned every two hours. On 11/25/15, at 9:14 a.m. TMA-A stated R13 should be turned and repositioned every two hours.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 10 R3's was not provided incontinence cares every two hours as directed by the care plan. R3's care plan identified on 2/11/15, a problem area for bowel status. The interventions directed staff to toilet R3 every night before bed, provide extensive assist with managing incontinence and perineal cares twice a day and after each incontinent episode. In addition, R3's care plan identified on 7/28/15, a problem area for urinary status and directed staff to provide extensive assist with incontinence episodes and to check and change R13's incontinent product every two hours. On 11/24/15, R3 was continuously observed from 7:10 a.m. until 10:13 a.m. (three hours and three minutes). During this time, R3 remained in her room lying on her back without personal care assistance. -At 7:21 a.m. dietary assistant (DA)-A entered R3's room and placed a breakfast tray on the over bed table and raised the head of the bed. DA-A lacked offering R3 toileting assistance. -At 10:13 a.m. NA-C knocked on the door, walked into room and took the breakfast tray from in front of R3. NA-C started a bed bath on R3, then opened R3's brief which was full of bowel movement and urine. On 11/24/15, at 1:50 p.m. RN-B and the DON confirmed it was their expectation for staff to follow R3's care plan with regards to R3 being checked and changed every two hours as directed by R3's care plan.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 11 On 11/25/15, at 10:06 a.m. trained medication assistant (TMA)-A stated R3 should be checked and changed every two hours. R15's was not provided oral cares as directed by the care plan. R15's care plan dated 9/16/15, identified R15 had a deficit with self-care performance with activities of daily living (ADL's) and required extensive assist with personal hygiene cares and directed staff to provide mouth cares due to Gouty tophi (gout complications) on R15's hands. On 11/24/15, at 7:28 a.m. NA-A was observed to enter R15's room and proceed to complete R15's personal cares. NA-A was observed to bathe R15 in her bed, provide personal cares and dress her. NA-A utilized an over-head lift to transfer R15 to her wheelchair. NA-A combed her hair and then opened a denture dish and inserted R15's top plate into her mouth. R15's lips were observed dry with a thin line of white matter at the corners of her mouth. During this observation R15 was not offered or assisted with oral cares. -from 7:53 a.m. to 9:50 a.m. R15 was observed to consume breakfast and was assisted to the common activity area and situated at one of the tables. R15 was not offered or assisted with oral care. On 11/24/15, at 1:56 p.m. NA-A verified she did not provide R15 oral cares before or after	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 12 breakfast. NA-A stated she usually used swabs and mouthwash to clean R15's mouth and she should have done that. On 11/24/15, at 2:17 p.m. RN-A stated R15 should have been provided oral cares as directed by the care plan. On 11/24/15 at 3:50 p.m. the DON stated R15 should have been provided or offered oral cares during morning cares. The DON confirmed R15's care plan was not followed. Comprehensive Care Plans policy dated 10/10, indicated each resident's care plan was designed to incorporate identified problem areas and the appropriate professional services responsible for each element of care. In addition, care plan interventions where to be designed to address the underlying sources of the problem areas identified. Care Plans policy (undated) indicated all residents would have a comprehensive care plan which described the services which were to be furnished to the resident so the resident's highest practicable physical, mental and psychosocial well-being would be attained and maintained.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		1/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 13 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper labeling of a wound cleansing product was maintained after staff had replaced the contents of the product's container with sterile water. This had the potential to affect residents (R5, R13, R38) who currently had wounds which required routine treatments. Findings include: R13's Physician Order Report dated 10/25/15 - 11/25/15, identified R13's diagnosis as having a chronic non-pressure ulcer to his calf. In addition, R13's dressing to this non-pressure related ulcer on the right calf was ordered to be changed twice a day. 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	F 309	R5, R13 and R38 will have the proper labeled wound cleanser in the proper bottles for their wound treatments. All residents with wound cares will have the proper labeled bottles used for their dressing treatments. Other substances will not be poured from one bottle in to another. DON/designee will educate staff on 12/16/2015 at staff meeting on not replacing the contents of the product in a bottle with anything other than what is on the label. DON/designee will audit treatment supplies weekly to be sure that the proper cleansers are being used for dressing treatments, documented and brought to Quality Council Meeting by 01/20/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 14 removed the dried bloody stained stockinet from R13's right leg. TMA-B sprayed dermal wound cleanser (a first aid antiseptic spray with the active ingredient of Benzethonium chloride 0.13%) on the wound and removed the adhered 4 inch by 4 inch (4 x 4) 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 into the spray bottled labeled "dermal wound cleanser." TMA-B continued to spray the sterile water onto R13's wound and removed the remaining 4 x 4 gauze dressings and placed them in a nearby garbage. R13's right lateral lower leg stasis ulcer was visualized to be down to the bone; wound appeared raw and bloody with copious amounts of serosanguineous (yellowish drainage with small amounts of blood) that had went through the 4 x 4 gauze dressings, ABD dressing (a sterile highly absorbent dressing) and the stockinet. On 11/20/15, this wound had measured 23.5 centimeters (cm) in length by 5.5 cm wide and 2.0 cm deep. TMA-B opened and placed three sterile packages of 4 x 4 gauze dressings and applied them to R13's wound. TMA-B placed an ABD dressing over the 4 x 4 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 gloves, cleaned up the supplies and washed his hands in the bathroom sink. TMA-B brought the bin of supplies (which included the spray bottle labeled dermal wound cleanser, however which contained sterile water) back to the medication drawer at the nursing station for others to use. On 11/24/15, at 1:24 p.m. TMA-B confirmed the	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 15 spray bottled labeled "dermal wound cleanser" still contained sterile water. On 11/24/15, at 1:46 p.m. RN-B verified sterile water had been poured into the spray bottled labeled "dermal wound cleanser" and this container had not been tossed or relabeled. RN-B and the director of nursing (DON) confirmed this was not the facility's policy to do this and the bottle should have been tossed. No policy related to correct labeling of products or replacing the contents of a labeled bottle with another solution was provided.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with bowel and bladder incontinence cares for 1 of 3 residents (R3) reviewed for incontinence care. In addition, the facility failed to provide oral cares for 1 of 2 residents (R15) who required assistance with oral cares. Findings include:	F 312	R15 will receive oral care twice daily per her plan of care. R3 will receive timely incontinent care according to her plan of care. DON/designee will ensure that all residents receive timely incontinent care and oral care by daily auditing of both. Staff will receive just in time training up to disciplinary action if the plan of care is not being followed. All residents will be assessed by DON/designee to ensure	1/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 16 R3 was not provided incontinence care for over 3 hours on the morning of 11/24/15. R3's quarterly Minimum Data Set (MDS) dated 8/28/15, indicated R3 had moderate cognitive impairment, was frequently incontinent of bowel and bladder, had limited range of motion in the lower extremities bilaterally and required extensive assistance with bed mobility, transferring, toileting and personal hygiene. R3's Activity of Daily Living (ADL) Care Area Assessment (CAA) dated 3/4/15, indicated R3 was frequently incontinent of urine, required extensive assistance with toileting and was on an every two hour toileting program throughout the day. R3's care plan identified on 2/11/15, a problem area for bowel status and directed staff to toilet R3 every night before bed, provide extensive assist with managing incontinence and perineal cares twice a day and after each incontinence episode. In addition, R3's care plan identified on 7/28/15, a problem area for urinary status and directed staff to provide extensive assist with incontinence episodes and to check and change R13's incontinent brief every two hours. R3's bladder assessment dated 8/25/15, indicated R13 was frequently incontinent of bladder and that since R13 refused to use the toilet most of the time she had been switched to a check and change schedule throughout the day.	F 312	that they have appropriate incontinent and oral cares in place in their plan of care. Staff will be educated on 12/16/15 at monthly staff meeting. Audits will be reviewed at Quality Council on 1/20/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 17 R3's bowel assessment dated 8/25/15, indicated R13 was frequently incontinent of bowel and that R13 had been changed to a check and change incontinence schedule. R3's Resident Admission Record printed on 11/25/15, indicated R3's diagnoses to include heart failure, depression, dysuria (painful or difficult urination) and constipation. On 11/24/15, R3 was continuously observed from 7:10 a.m. until 10:13 a.m. (three hours and three minutes). During this time, R3 remained in her room lying on her back. -At 7:21 a.m. dietary assistant (DA)-A entered R3's room and placed a breakfast tray on the over bed table and raised the head of the bed. DA-A lacked offering R3 toileting assistance. -At 10:13 a.m. nursing assistant (NA)-C knocked on R3's door, walked into room and took the breakfast tray from in front of R3. NA-C proceeded to start R3's bath. when NA-C opened R3's incontinent brief, the brief was full of bowel movement and urine. On 11/24/15, at 10:50 a.m. NA-C stated R3 was to be checked and incontinent brief changed and also repositioned every three hours. On 11/24/15, at 1:50 p.m. registered nurse (RN)-B and the director of nursing (DON) confirmed it was their expectation for staff to follow R3's care plan with regards to R3 being checked and changed every two hours.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 18 On 11/25/15, at 10:06 a.m. trained medication assistant (TMA)-A stated R3 should be checked and changed every two hours. No policy related to incontinence care specific for checking and changing was provided. R15 was not provided oral care as directed by the care plan. R15's quarterly Minimum Data Set (MDS) dated 8/28/15, identified R15's diagnoses as depression and diabetes. The MDS also indicated R15 had moderate cognitive impairment and required extensive assist with personal hygiene cares. R15's care plan dated 9/16/15, identified R15 had a deficit with self-care performance with ADL's and required extensive assist with personal hygiene cares and directed staff to provide mouth cares due to Gouty tophi (gout complications) on R15's hands. On 11/24/15, at 7:28 a.m. NA-A was observed to enter R15's room and proceed to complete R15's personal cares. NA-A was observed to bathe R15 in her bed, provide personal cares and dress her. NA-A utilized an over-head lift to transfer R15 to her wheelchair. NA-A combed R15's hair, opened a denture dish and inserted R15's top plate into her mouth. R15's lips were observed dry with a thin line of white matter at the corners of her	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 19 mouth. During this time R15 was not offered or assisted with oral cares. On 11/24/15, from 7:53 a.m. to 9:50 a.m. R15 was observed to eat and finish her breakfast meal. Following breakfast, R15 was assisted to the common activity area and situated at one of the tables. During this time, R15 was not offered or assisted with oral care. On 11/24/15, at 1:56 p.m. NA-A verified she did not provide oral cares to R15 during morning cares or following the breakfast meal. NA-A stated she usually utilized swabs and mouthwash to clean R15's mouth and she should have done that. On 11/24/15, at 2:17 p.m. RN-A stated R15's oral cares should have been provided as R15 was on oxygen and her mouth got dry. On 11/24/15 at 3:50 p.m. the DON confirmed R15 should have had or been offered mouth care during morning cares. The facility, Oral hygiene policy (undated) indicated nursing staff would provide all residents with mouth care every morning, night and as needed. Care Plans policy (undated) indicated all residents would have a comprehensive care plan which described the services which were to be	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify, assess and implement appropriate interventions for a resident who developed two stage II pressure related ulcers for 1 of 3 residents (R13) who developed two stage II pressure ulcers at the facility. This resulted in actual harm for R13. Findings include: R13's significant change Minimum Data Set (MDS) dated 8/24/15, indicated R13 had severe cognitive impairment, was frequently incontinent of bowel and bladder, required extensive assist with bed mobility, transferring, toileting and	F 314	R13 was placed on Q1HR repositioning on 11/24/15 after RN was made aware of pressure ulcers. R13□s pressure ulcers were healed by 12/15/15, evidenced by the skin team evaluation and resident passed away on 12/16/15. Resident was already on a nutritional supplement, pressure reduction mattress, #3 creams BID and with cares. All residents skin is assessed weekly with bath and daily with cares. Nursing staff will be educated on 12/16/15 at our staff meeting on reporting any open area to Charge Nurse. Charge Nurse will then open an event and put in progress note in Matrix. DON/designee will review progress notes daily for any change in residents skin condition and make sure events for all skin impairments are completed, and will implement	1/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 21 personal hygiene. In addition, R13 was identified as being at risk for pressure ulcer development, had existing venous and arterial ulcers and more than one pressure ulcer. Skin treatment included pressure reducing device in R13's chair and bed, turning and repositioning program and pressure ulcer care. R13's Care Area Assessment (CAA) dated 8/26/15, indicated R13 was at risk for skin impairment and had pressure ulcers and stasis ulcers noted. Factors for R13's care plan included provide assistance with cares and bed mobility, skin treatments as ordered, monitor skin integrity and report any reddened, irritated or open areas to the charge nurse, pressure relieving devices in chair and bed, encourage/remind resident to change position at least every two hours and weekly skin check by nursing staff. R13's Pressure Ulcer Healing Chart initiated on 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 healed on 10/16/15. R13 had been on an every one hour turning schedule from 8/28/15 - 9/25/15. R13' s care plan dated 9/2/15, identified skin integrity as a problem area. The interventions 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. The care plan also indicated on 4/25/15, R13 had right	F 314	interventions as needed, along with communicating those changes with staff. Wound rounds are also completed weekly with DON/designee and discussed at Inter-disciplinary Team weekly. Audits will be reviewed at Quality Council on 1/20/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 22 lower extremity stasis (vascular) ulcers and history of a stage two gluteal ulcer. In addition, the care plan indicated R13 was receiving hospice services. Hospice services directed staff to reposition R13 at least every two hours and when needed. R13's Physician Order Report dated 10/25/15 - 11/25/15, identified R13's diagnoses as chronic anemia, anxiety, chronic non-pressure ulcer to calf, dementia, heart failure and palliative care. The report also directed staff to reposition and/or offload (relieve pressure to area) R13 every two hours or more often and to avoid pressure to affected area. In addition, pressure and stasis ulcers should be measured and documented on weekly. R13's Braden Scale (tool used to asses a resident's level of risk for development of a pressure ulcer) dated 11/17/15, indicated R13 was at a high risk for development of a pressure ulcer. Interventions included bilateral heel protectors, pressure relieving devices to chair and bed, every two hour turning/repositioning program, dressing changes and application of ointments. R13's Tissue Tolerance (assessment used to determine the skin's ability to withstand pressure without change) dated 11/18/15, indicated R13 should be placed on an every two hour turning/repositioning scheduled. On 11/24/15, at 8:03 a.m. nursing assistant	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 23 (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 (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough), 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 bed to R13's wheelchair which had a pressure relieving cushion in its seat. -At 8:38 a.m. NA-B transported R13 out into the common area and positioned R13's wheelchair near the fire place. R13 had a blue foam boot on his right foot. -At 9:10 a.m. R13 complained of being cold and trained medication aide (TMA)-B retrieved another blanket and placed over R13's shoulders. R13 remained seated in his wheelchair in the common area, until 10:10 a.m. when TMA-B transported R13 back to his room. -At 10:13 a.m. TMA-B with the assistance of registered nurse (RN)-B completed a dressing change to R13's right lower leg. R13 remained seated in the wheelchair during the dressing change. On 11/24/15, at 10:24 a.m. RN-B and TMA-B stated they were both unaware of any open areas on R13's buttocks. RN-B stated in the past R13 had had some open sores on the buttocks, but as	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 24	F 314		

far as RN-B was aware R13 did not have any current breakdown on his bottom now.
-At 10:28 a.m. RN-B confirmed pressure ulcers were measured weekly during wound rounds. The weekly wound rounds were conducted by herself, the director of nursing (DON) and the other RN. RN-B verified the weekly wound assessments included measurements of the wound and documentation of the wounds on the Pressure Ulcer Healing Chart.

On 11/24/15, at 10:40 a.m. (two hours and 25 minutes since R13 had last been repositioned) TMA-B and RN-B transferred R13 from the wheelchair back to R13's bed. RN-B removed R13's dry brief and confirmed R13 had two open areas on his buttocks and R13's bottom was reddened. TMA-B retrieved a measuring tape and RN-B measured both open areas. RN-B verified the pressure ulcer on the right side measured 0.7 cm in length x 0.6 cm in width and the pressure ulcer on the left measured 0.7 cm x 0.8 cm. RN-B confirmed both of these pressure ulcers where new.

R13's weekly skin and pain assessment notes located in the resident progress note section of the electronic medical record indicated the following:
· 11/5/15, assessment completed by TMA-B - stasis ulcer on right lateral lower leg; right great with black eschar (a dry dark scab); right lateral foot near the small toe had a darken scab, all other skin was in fair condition (no mention of any open areas on R13's buttocks)
· 11/12/15, assessment completed by licensed practical nurse (LPN)-A indicated stasis ulcer on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 25 right lateral lower leg, right great toe and second toe black; right lateral foot near the small toe had a small eschar cap and a small area on his heel that had a darkened scab and one open area on buttocks (location of wound not specified nor a measurement or stage identified) * 11/16/15, hospice progress note completed by RN-D identified R13's lower right leg wound and foot wounds, however, failed to identify buttock wound. · 11/20/15, assessment completed by LPN-A indicated status ulcer on right lateral lower leg measured 23.5 cm x 5.5 cm x 2.0 cm; right great toe remained black; other toes on right foot have started to turn black; lateral right foot has eschar cap; back of the heel had opened and measured 3.5 cm x 2.0 cm; one open area on buttocks (location of wound not specified nor a measurement or stage identified). On 11/24/15, at 12:47 p.m. RN-B confirmed R13 was at risk for the development of a pressure ulcer. In addition, RN-B verified the aforementioned progress note dated 11/20/15, had indicated R13 had one open area on his buttock and stated she was not notified of the new open area and the ulcer was not measured. On 11/24/15, at 12:52 p.m. RN-B confirmed both pressure ulcers on R13's buttocks were stage II pressure ulcers and even though it was hard to say, with the interventions in place R13's pressure ulcer could have been avoidable. RN-B stated anyone who had a current pressure ulcer should have been placed on an every one hour turning/repositioning schedule. RN-B stated R13	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 26 was now changed to an every one hour turning/repositioning schedule. R13's Pressure Ulcer Skin Note dated 11/24/15, verified R13 had two open areas on buttocks which measured: · right - 0.5 cm x 0.6 cm · left - 0.6 cm x 0.7 cm On 11/24/15, at 1:50 p.m. RN-B and the DON confirmed it was their expectation for staff to follow R13's care plan with regards to R13's turning and repositioning schedule and other pressure ulcer prevention interventions. On 11/25/15, at 9:08 a.m. NA-B stated R13 should be repositioned every two hours and if any breakdown was noticed, staff were to inform the medication nurse. NA-B was unaware that R13's turning/repositioning scheduled had been changed from every two hours to every one hour as stated by RN-B on 11/24/15, at 12:52 p.m. On 11/25/15, at 9:14 a.m. TMA-A stated R13 should be turned and repositioned every two hours. TMA-A was unaware R13's turning/repositioning schedule had been changed from every two hours to every one hour as stated by RN-B on 11/24/15, at 12:52 p.m. R13's care plan provided on 11/25/15, by the DON failed to reflect the change from an every two hour repositioning/returning schedule to an every one hour repositioning/turning schedule as	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 27 stated by RN-B on 11/24/15, at 12:52 p.m. The facility's Turning and Repositioning policy (undated) indicated residents would receive the necessary turning and repositioning to meet the specific needs to promote healing existing pressure ulcers, prevent reoccurrences of pressure ulcers and to prevent new pressure ulcer development. In addition, if a resident's skin was impaired related to a pressure ulcer, and once the area had healed, the resident would remain on a turning and repositioning schedule of every one hour for six months. The facility's Pressure Ulcer Assessment policy dated 2/25/11, indicated staff would document the notification/observation of any pressure ulcer immediately. Follow up documentation would be accomplished at least weekly or upon significant change in the ulcer area. In addition, tissue tolerance to pressure would be maintained and improved.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329		1/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 28 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to identify target behaviors and identify and implement non pharmacological interventions for 1 of 1 resident (R49) who received an as needed (PRN) anti-anxiety medication. In addition, the facility failed to monitor the sleep pattern for the use of hypnotic medication for 1 of 1 resident (R5) who recieved a hypnotic, had a dose change and lacked documentation related to the effectiveness of the medication. Findings include: R49 received PRN lorazepam (antianxiety medication) and target behaviors and nonpharmacological interventions had not been identified or consistently implemented.	F 329	R49 will have clearly outlined targeted behaviors and outlined non-pharmaceutical interventions to trial before the use of PRN anti-anxiety medication according to their plan of care. R5 will have proper monitoring of sleep pattern with current use of hypnotic according to their plan of care. All residents will not receive psychotropic drugs unless psychotropic drug therapy is necessary to treat a specific condition or diagnosis and non-pharmacological interventions are tried prior to administering medication. All resident will receive proper monitoring of sleep patterns with current use of hypnotic medications according to plan of care. DON/Designee will ensure that all psychotropic medications will have target behaviors listed in the order of the medication specified to be given for target behaviors. That monitoring effectiveness	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 29 R49's admission Minimum Data Set dated 8/31/15, indicated R49 had severe cognitive impairment, showed no signs of psychosis or behavior towards self or others. In addition, R49 had received one dose of PRN antianxiety medication during the seven day observation period of this assessment. R49's Psychotropic Medication Use Care Area Assessment (CAA) dated 8/31/15, indicated R49 was at risk for side effects due to the use of an antianxiety medication. The CAA lacked identification of target behaviors and nonpharmacological interventions to be implemented prior to the administration of the antianxiety medication. R49's care plan identified on 8/18/15, a problem area for psychotropic medication use. The interventions directed staff to monitor for side effects of the psychotropic medication and for the physician and pharmacist review to be conducted per guidelines for gradual dose reduction. R49's care plan lacked identification of target behaviors for the use of the PRN lorazepam and nonpharmacological interventions to be attempted prior to the administration of the antianxiety medication. R49's Physician Order Report dated 10/25/15-11/25/15, indicated R49 had diagnoses that included chronic obstructive pulmonary disease, anxiety disorder, heart failure and dementia. In addition, on 8/18/15, the physician had ordered lorazepam 0.5 milligrams (mg) that could be given PRN up to three times a day for	F 329	of all psychotropic in the order is in place. Care plans will be adjusted as changes are made to include target behaviors and non-pharmacological interventions as well as pharmacological interventions. Staff will be educated at monthly staff meeting on 12/16/15. DON/Designee will perform weekly audits of PRN psychotropic use and ensure staff are documenting properly on PRN psychotropic use and trialing non-pharmacological interventions first per their plan of care. If documentation is not in place just in time is given to staff member to make changes/proper documentation of progress note. Orders will be added on all changed psychotropic medication to monitor for effectiveness of change for 30 days after medication is changed. DON/Designee will perform monthly audits to ensure all changes to psychotropic medications are being monitored for effectiveness at the monthly psychotropic meeting. Audits will be reviewed at Quality Council on 01/20/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 30 generalized anxiety. However, the order had not identified specific target behaviors for the use of the PRN lorazepam. R49's informed consent for psychotropic medications dated 1/17/15, listed lorazepam 0.5 mg PRN up to two times a day for anxiety. The section of the consent form which requested that target behaviors be noted in specific terms, lacked identification of target behaviors for the use of the lorazepam. R49's PRN Medications Administration History dated 9/1/15 - 11/25/15, indicated R49 had received lorazepam 0.5 mg on 9/13/15, 9/14/15, 9/24/15, 10/5/15, 10/19/15, and 10/29/15. The lorazepam 0.5 mg had been administered for a variety of reasons such as picking her nose, self-transferring, restlessness and yelling out. R49's medical record lacked documentation with regards to nonpharmacological interventions attempted prior to the administration of the lorazepam on 9/13/14, 9/14/15, and 10/29/15. On 11/24/15, at 9:31 a.m. R49 was observed in the dining room, seated in her wheelchair. R49 is well groomed, has oxygen on and eating her breakfast independently. On 11/24/15, at 9:58 a.m. R49 was observed seated in a recliner by the fireplace in the common area. R49 had her feet elevated, oxygen on and eyes closed.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 31 On 11/24/15, at 3:40 p.m. trained medication aide (TMA)-B stated R49 received the PRN lorazepam when R49 attempted to self-transfer because she wanted to get up and go to the bathroom. TMA-B confirmed R49 lacked identification of nonpharmacological interventions to be attempted prior to the administration of the PRN lorazepam. TMA-B stated they just would try different things. On 11/24/15, at 3:43 p.m. registered nurse (RN)-B confirmed target behaviors and nonpharmacological interventions had not been specifically identified or consistently documented for the utilization of the PRN lorazepam for R49. RN-B stated the licensed social worker (LSW)-A usually developed the psychotropic portion of the care plan which would list the target behaviors and nonpharmacological interventions. On 11/24/15, at 4:10 p.m. the consulting pharmacist (CP) stated target behaviors and nonpharmacological interventions should have been identified and consistently utilized for R49's PRN use of the lorazepam. On 11/25/15, at 8:30 a.m. LSW-A confirmed target behaviors and nonpharmacological interventions had not been specifically identified for R49's PRN use of the lorazepam. No policy on the development and implementation of target behaviors and nonpharmacological interventions was provided.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 32	F 329		

R5's clinical record lacked sleep pattern monitoring for the continued use of a hypnotic medication.

R5's quarterly MDS dated 8/23/15, indicated R5 was diagnosed with diabetes, a stroke and insomnia. The MDS also indicated R5 had intact cognition and required extensive assistance with bed mobility, transfers and was unable to ambulate.

R5's current Physicians orders included an order started on 11/28/14, for Zaleplon (hypnotic medication). The orders indicated the medication was decreased to 10 milligrams at bedtime on 11/6/15. The orders also directed staff to chart R5's sleeping behavior and pattern if it had improved or not.

R5's care plan dated 12/22/14, directed staff to administer Zaleplon for insomnia and monitor for side effects.

R5's Progress Note dated 11/6/15, indicated R5 had been evaluated by the psychiatrist and the Zaleplon was decreased to 10 mg at bedtime as it may cause an increase in sleep apnea.

R5's Physician clinic notes dated 11/12/15, indicated R5 had not been sleeping well and was frequently up throughout the night. R5 had displayed irritability towards the staff and aggressive behaviors. A sleep study was ordered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 33 at that time. R5's clinical record lacked any indication of sleep pattern monitoring and / or documentation. On 11/24/15, at 12:24 p.m. RN-A stated R5 had difficulty sleeping and a sleep study had been scheduled for December 2015. She stated the nurses were to be documenting his sleep pattern since the hypnotic medication had just been reduced on 11/6/15. RN-A then reviewed R5's progress notes / clinical record and confirmed the facility had not documented on R5's sleep patter since his medication dose had been changed. On 11/24/15, at 3:50 p.m. R5 stated he routinely went to bed around 6:00 p.m. He stated he only slept well when he took the medications. A policy regarding medication monitoring was requested and none was provided.	F 329		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.	F 406		1/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 406	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a level II Preadmission Screening and Resident Review (PASRR) was completed for 1 of 1 resident (R58) who was assessed with intellectual disabilities. Findings include: R58's hospital consult note dated 10/27/15, from Sanford Medical Center Fargo indicated R58's diagnoses included Prader-Willi (rare genetic disorder characterized by cognitive disabilities and chronic feeling of hunger), developmentally delayed and anxiety. R58 had resided in a group home prior to her admission to the hospital. R58's Progress note dated 11/6/15, indicated R58 was disabled and required extensive assist with transfers and toileting. R58's The Pre-Admission Screening Assessment (PAS/OBRA Level I) dated 11/5/15, indicated a Level II Developmental Disability Evaluation and final review of the need for specialized services was required by placing a check mark next to the statement of such. On 11/23/15, at 12:54 p.m. a late entry for 11/20/15, had been entered into R58's resident progress notes by licensed social worker	F 406	R58 has been discharged and counties have been contacted to complete Level II screening. An audit was completed 12/14/2015 on all current residents to ensure they didn□t trigger for a LEVEL II screen prior to admission. No current resident triggered for a LEVEL II screen. To ensure this incident will not happen again the facility will not admit anyone that triggers for a LEVEL II screen without first having documentation that the screen completed prior to admission. Current Policy is consistent with this process. LSW was educated on the process of LEVEL II screen requirements for MN law. LSW educated DON as DON is back up for admissions on 1/16/15 .All LOC documentation will be reviewed on new Admissions monthly at Quality Council beginning January. If a resident has triggered for a level II screen and audit will be conducted to ensure a screen was completed prior to admission.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 406	Continued From page 35	F 406		

(LSW)-A. This note indicated a message had been left with Norman county social services (NCSS) for an update on the level II PASRR screening for R58.

On 11/23/15, at 3:10 p.m. R58 was observed participating in the chair yoga activity in the common area.

On 11/23/15, at 7:02 p.m. R58 was seated in the common area in her wheelchair where she ate a snack and conversed with staff and other residents.

On 11/24/15, at 9:03 a.m. a late entry for 11/23/15, had been entered into R58's resident progress notes by LSW-A indicating another message had been left with NCSS regarding the PASRR screening for R58.

R58's progress note dated 11/24/15, at 9:53 a.m. indicated LSW-A had contacted NCSS and the NCSS representative had confirmed the level II PASRR screening hadn't been completed and she was going to check with her supervisor.

On 11/24/15, at 11:30 a.m. R58 was observed in the rehabilitation department participating in a therapy session.

On 11/25/15, at 8:23 a.m. LSW-A confirmed R58's level II PASRR screening had not been completed. LSW-A stated she thought the county

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 406	Continued From page 36 had ten days to complete this screening. LSW-A stated the county representative had informed her there had been a miscommunication and the level II PASRR screening for R58 had been missed. At this time, LSW-A was unaware of when the screening would be completed. On 11/25/15, at 9:30 a.m. R58 was observed in the dining room eating her breakfast. R58 stated she used to have a job at the occupational development center (ODC) where she placed labels on papers and also put papers in a shredder machine. R58 stated she missed her job. The Admission Prescreening for Individuals with Mental Retardation or Mental Illness dated 4/12, indicated a nursing facility was not to admit any resident with an intellectual or developmental disability until authority had determined prior to admission that the individual required that level of service provided by the facility and whether or not the individual required specialized services.	F 406		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		1/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the pharmacist identified the lack of target behaviors and non pharmacological interventions to be attempted prior to the administration of an as needed (PRN) anti-anxiety medication for 1 of 1 resident (R49) who received anti-anxiety medications without the aforementioned identified. In addition the pharmacist failed to identify the lack of sleep pattern monitoring for 1 of 1 resident (R5) who received hypnotic medications. Findings include: R49 recieved PRN lorazepam (antianxiety medicaiton) without target behaviors for the use of the medication identified nor non pharmacological interventions to be attempted prior to the administration of the medication. R49's admission Minimum Data Set (MDS) dated 8/31/15, indicated R49 had severe cognitive impairment, showed no signs of psychosis or behavior towards self or others. In addition, R49 had received one dose of PRN antianxiety medication during the seven day observation period of this assessment. R49's psychotropic medication use Care Area Assessment (CAA) dated 8/31/15, indicated R49 was at risk for side effects due to the use of an	F 428	R49 will have non- pharmacological interventions listed in her progress note prior to giving her prn anxiety medication. R5 had sleep monitoring put in place to reflect his sleep after the change in hypnotic starting on 12/16/15. DON/designee will ensure that all residents on prn psychotropic medications have documentation on non-pharmacological interventions prior to giving medication and residents with changes in hypnotics will be monitored for sleep by educating staff at monthly staff meeting on 12/16/15. DON/designee will audit all prn psychotropic weekly to ensure proper documentation is present and educate staff with just in time training as needed. DON/designee will audit residents with changes in sleep medications at our monthly psychotropic meeting. Pharm D will audit that residents with hypnotic changes will have sleep monitoring completed on her monthly visit. Pharm D will also audit that all residents who receive prn psychotropic have progress notes listed on her monthly visit and report her findings to the DON. Audits will be reviewed at Quality Council on 1/20/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 38 antianxiety medication. The CAA lacked identification of target behaviors and nonpharmacological interventions to be implemented prior to the administration of the antianxiety medication. R49's Physician Order Report dated 10/25/15-11/25/15, indicated R49 had diagnoses that included chronic obstructive pulmonary disease, anxiety disorder, heart failure and dementia. In addition, on 8/18/15, the physician had ordered lorazepam 0.5 milligrams (mg) that could be given PRN up to three times a day for generalized anxiety. However, the order had not identified specific target behaviors for the use of the PRN lorazepam. R49's care plan identified on 8/18/15, a problem area for psychotropic medication use. The interventions directed staff to monitor for side effects of the psychotropic medication and for the physician and pharmacist review to be conducted per guidelines for gradual dose reduction. R49's care plan lacked identification of target behaviors for the use of the PRN lorazepam and nonpharmacological interventions to be attempted prior to the administration of the antianxiety medication. R49's informed consent for psychotropic medications dated 1/17/15, listed lorazepam 0.5 mg PRN up to two times a day for anxiety. The section of the consent form which requested that target behaviors to be noted in specific terms, lacked identification of target behaviors for the use of the lorazepam.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 39	F 428		

R49's PRN Medications Administration History dated 9/1/15 - 11/25/15, indicated R49 had received lorazepam 0.5 mg on 9/13/15, 9/14/15, 9/24/15, 10/5/15, 10/19/15, and 10/29/15. The lorazepam 0.5 mg had been administered for a variety of reasons such as picking her nose, self-transferring, restlessness, and yelling out. R49's medical record lacked documentation with regards to nonpharmacological interventions attempted prior to the administration of the lorazepam on 9/13/14, 9/14/15, and 10/29/15.

Review of the pharmacists monthly medication review for R49, from 8/23/15 - 11/5/15, lacked mention of the need for the identification of target behaviors and nonpharmacological interventions for the utilization of R49's PRN lorazepam.

On 11/24/15, at 3:43 p.m. registered nurse (RN)-B confirmed target behaviors and nonpharmacological interventions had not been specifically identified or consistently documented for the utilization of the PRN lorazepam for R49. RN-B stated the licensed social worker (LSW)-A usually developed the psychotropic portion of the care plan which would list the target behaviors and nonpharmacological interventions.

On 11/24/15, at 4:10 p.m. the consulting pharmacist (CP) confirmed target behaviors and nonpharmacological interventions should have been identified and consistently utilized for R49's PRN use of the lorazepam. The CP stated she tried to make sure these were identified and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 40 documented as part of the monthly pharmacy medication regime reviews. On 11/25/15, at 8:30 a.m. LSW-A confirmed target behaviors and nonpharmacological interventions had not been specifically identified for the R49's PRN use of the lorazepam. No policy on the development and implementation of target behaviors and nonpharmacological interventions was provided. R5's clinical record lacked sleep pattern monitoring for the continued use of a hypnotic medication. R5's quarterly MDS dated 8/23/15, indicated R5 was diagnosed with diabetes, a stroke and insomnia. The MDS also indicated R5 had intact cognition and required extensive assistance with bed mobility, transfers and was unable to ambulate. R5's current Physicians orders included an order started on 11/28/14, for Zaleplon (hypnotic medication). The orders indicated the medication was decreased to 10 mg at bedtime on 11/6/15. The orders also directed staff to chart R5's sleeping behavior and pattern if it had improved or not. R5's care plan dated 12/22/14, directed staff to administer Zaleplon for insomnia and monitor for side effects.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 41	F 428		

R5's Progress Note dated 11/6/15, indicated R5 had been evaluated by the psychiatrist and the Zaleplon was decreased to 10 mg at bedtime as it may cause an increase in sleep apnea.

R5's Physician clinic notes dated 11/12/15, indicated R5 had not been sleeping well and was frequently up throughout the night. R5 had displayed irritability towards the staff and aggressive behaviors. A sleep study was ordered at that time.

R5's clinical record lacked any indication of sleep pattern monitoring and / or documentation.

On 11/24/15, at 12:24 p.m. RN-A stated R5 had difficulty sleeping and a sleep study had been scheduled for December 2015. She stated the nurses were to be documenting his sleep pattern since the hypnotic medication had just been reduced on 11/6/15. RN-A then reviewed R5's progress notes and confirmed the facility had not documented on R5's sleep pattern since his medication dose had been changed.

On 11/24/15, at 3:50 p.m. R5 stated he routinely went to bed around 6:00 p.m. He stated he only slept well when he took the medications.

Review of the pharmacist Progress Notes indicated R5 was receiving Zaleplon 15 mg at bedtime on 5/7/15. The pharmacist note dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 42 11/5/15, indicated the Zaleplon had been reduced and the staff were to continue to monitor sleep. However, the clinical record lacked documentation related to sleep pattern monitoring. On 11/24/15, at 4:10 p.m. the CP stated she had identified the Zaleplon 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 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		1/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 43 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand washing technique was performed during wound care for 2 of 2 residents (R5, R13) observed during dressing change. Findings include: R5 was observed to receive wound care and the staff member failed to perform appropriate hand washing during the provision of the treatment. On 11/25/15, at 7:54 a.m. registered nurse	F 441	R13 will receive proper dressing changes with hand washing and new pair of gloves placed on prior to application of new clean/sterile product. R5 will receive hand washing and new gloves prior to applying solution to heel and before re-applying dressing. All residents will receive proper dressing changes with hand washing and clean gloves prior to application of new clean/sterile products. DON/Designee will ensure that LPN/TMA/RN staff is completing proper hand washing and dressing application by weekly auditing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 44 (RN)-A was observed to approach R5 while he was seated in a wheelchair in his room. RN-A removed R5's foam boot, sock and peeled back the transparent dressing covering a wound on the left heel. RN-A was not wearing gloves when she removed the old dressing. The wound was observed to be a thick black scab (eschar) and was not draining. RN-A measured the wound to be 2.0 centimeters (cm) by 1.3 cm. RN-A left the room to gather additional dressing supplies. She approached the medication nurse and asked for additional dressing supplies. RN-A was not observed to wash her hands prior to leaving the room. RN-A then returned to the room, applied a betadine solution to the wound and covered the wound with the old dressing. RN-A was not observed to wear gloves during the procedure. RN-A then applied R5's sock and replaced the foam boot. At 8:00 a.m. RN-A opened the door, left the room and walked to the neighborhood kitchenette and washed her hands. On 11/25/15, at 8:05 a.m. RN-A verified she had not worn gloves during the dressing change nor had she washed her hands during the procedure. She verified gloves should have been worn during the procedure. R13 was observed to receive wound care and the staff member failed to perform appropriate hand washing during the provision of the treatment. R13's Physician Order Report dated 10/25/15 - 11/25/15, identified R13's diagnoses as anemia, anxiety, chronic non-pressure ulcer to calf, dementia, heart failure and hypertension. In	F 441	with dressing changes to ensure proper hand washing, dressing application and infection control measures are completed for each resident. Care plans will be adjusted as changes are made. Staff will be educated at monthly staff meeting on 12/16/15. Audits will be reviewed at Quality Council on 01/20/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 45 addition, R13's dressing to the non-pressure related ulcer on the right calf was ordered to be changed twice a day. 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 on the wound and removed the adhered 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 into the spray bottled labeled "dermal wound cleanser." TMA-B continued to spray 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 (yellowish drainage with small 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	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 46 gloves, cleaned up the supplies and washed his hands in the bathroom sink. 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, mucous 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 glove 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 again and a clean pair of gloves donned; the wound should	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 47 be cleansed and new clean dressings applied; gloves should be removed and hands washed and dried following completion of the dressing change.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure wheelchair armrests were maintained in a clean, safe and sanitary condition for 3 of 3 residents (R49, R56, R7) who had torn, loose or uncleanable arm rests. Findings include: On 11/23/15, at 2:32 p.m. R49's right wheelchair arm rest was observed very loose, wobbly. On 11/23/15, at 3:13 p.m. R56's wheelchair arm rests were observed uncovered with padding exposed. On 11/23/15, at 5:29 p.m. R7 was observed seated in the wheelchair. R7's wheelchair arm rests were observed torn and cracked.	F 465	R49, R56, & R7 all received new arm rests. All resident□s w/c arm rest was audited by DON to ensure that they are in good condition. All poor quality arm rests were replaced. DON/designee will audit arm rests monthly for poor quality and replace prn. Staff will be educated on 12/16/15 to report poor quality arm rest to DON/designee for replacement. Audits will be report to Quality Council on 1/20/2016.	1/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 48 On 11/24/15, at 12:45 p.m. the Environmental Director (ED) observed the aforementioned wheelchairs and verified R49's right wheelchair arm rest was missing screws and coming apart and stated it would be fixed. The ED verified R56's arm rests were uncovered with exposed, uncleanable padding and they would be replaced. In addition, the ED verified R7's arm rests were torn / cracked with exposed padding, uncleanable and in need of repair. The ED stated they would be replaced. -At 1:00 p.m. the ED stated the facility did not have a maintenance schedule specific for the monitoring of the wheelchair arm rest rather, the nursing staff were directed to submit a work order to maintenance when a wheelchair was in need of repair or replacement. The ED stated the facility did not have a policy and procedure related to the maintenance of wheelchairs / arm rests.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**11/24/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 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 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		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**11/24/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The sleeping rooms have single station smoke detectors that annunciate outside the room and at the nurse's station in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm system has automatic fire department notification. The facility has a capacity of 49 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **02 - CHAPEL** B. WING _____	**11/24/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 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 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 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		

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **02 - CHAPEL** B. WING _____	**11/24/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The sleeping rooms have single station smoke detectors that annunciate outside the room and at the nurse's station in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm system has automatic fire department notification. The facility has a capacity of 49 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

Minnesota Department of Health

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order.

This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ 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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 11/23/15, 11/24/15, and 11/25/15, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to develop a comprehensive behavior care plan which included target behaviors and nonpharmacological interventions for 1 of 1 resident (R49) who received an as needed (PRN) anti-anxiety medication. Findings include: R49's care plan identified on 8/18/15, a problem area for psychotropic medication use. The interventions directed staff to monitor for side effects of the psychotropic medication and for the physician and pharmacist review to be conducted per guidelines for gradual dose reduction. R49's care plan lacked identification of target behaviors	2 560	Corrected	1/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 3 for the use of the PRN lorazepam and nonpharmacological interventions to be attempted prior to the administration of the antianxiety medication. R49's Physician Order Report dated 10/25/15-11/25/15, indicated R49 had diagnoses that included chronic obstructive pulmonary disease, anxiety disorder, heart failure and dementia. In addition, on 8/18/15, the physician had ordered lorazepam 0.5 milligrams (mg) that could be given PRN up to three times a day for generalized anxiety. However, the order had not identified specific target behaviors for the use of the PRN lorazepam. R49's PRN Medications Administration History dated 9/1/15 - 11/25/15, indicated R49 had received lorazepam 0.5 mg on 9/13/15, 9/14/15, 9/24/15, 10/5/15, 10/19/15, and 10/29/15. The lorazepam 0.5 mg had been administered for a variety of reasons such as picking her nose, self-transferring, restlessness and yelling out. R49's medical record lacked documentation with regards to nonpharmacological interventions attempted prior to the administration of the lorazepam on 9/13/14, 9/14/15, and 10/29/15. On 11/24/15, at 3:43 p.m. registered nurse (RN)-B confirmed target behaviors and nonpharmacological interventions had not been specifically identified or consistently documented for the utilization of the PRN lorazepam for R49. RN-B stated the licensed social worker (LSW)-A usually developed the psychotropic portion of the care plan which would list the target behaviors and nonpharmacological interventions.	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 4 On 11/25/15, at 8:30 a.m. LSW-A confirmed target behaviors and nonpharmacological interventions had not been specifically identified on R49's care plan for the PRN use of the lorazepam. Care Plan policy (undated) indicated all residents would have a comprehensive care plan that included measurable objectives to meet the resident's medical, mental and psychosocial needs. The care plan would describe the services that would be furnished so the resident ' s highest practicable physical, mental and psychosocial well-being would be attained and maintained.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide every two hour turning and repositioning assistance as directed by the care plan for 1 of 3 residents (R13) identified at risk for pressure ulcers. The facility failed to provide incontinence cares as directed by the care plan for 1 of 3 residents (R3) who required assistance with incontinence cares and	2 565	Corrected	1/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	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 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 bottom and applied a clean brief. -At 8:15 a.m. NA-B transferred R13 from the bed to R13's wheelchair which had a pressure relieving cushion in its seat. -At 8:38 a.m. NA-B transported R13 out into the common area and positioned R13's wheelchair near the fire place. R13 had a blue foam boot on	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 6	2 565		

his right foot.
-At 9:10 a.m. R13 complained of being cold and trained medication aide (TMA)-B retrieved another blanket and placed over R13's shoulders. R13 remained seated in his wheelchair in the common area, until 10:10 a.m. when TMA-B transported R13 back to his room.
-At 10:13 a.m. TMA-B with the assistance of registered nurse (RN)-B completed a dressing change to R13's right lower leg. R13 remained seated in the wheelchair during the dressing change.
- At 10:40 a.m. (two hours and 25 minutes since R13 had last been repositioned) TMA-B and RN-B transferred R13 from the wheelchair back to R13's bed. RN-B removed R13's dry brief and confirmed R13 had two open areas on his buttocks and R13's bottom was reddened. TMA-B retrieved a measuring tape and RN-B measured both open areas. RN-B verified the pressure ulcer on the right side was 0.7 cm in length x 0.6 cm in width and the pressure ulcer on the left measured 0.7 cm x 0.8 cm. RN-B confirmed both of these pressure ulcers where new.

On 11/24/15, at 1:50 p.m. RN-B and the director of nursing (DON) confirmed it was their expectation for staff to follow R13's care plan with regards to R13's every two hours turning and repositioning schedule and other pressure ulcer prevention interventions.

On 11/24/15, at 9:08 a.m. NA-B stated R13 should be repositioned every two hours.

On 11/25/15, at 9:14 a.m. TMA-A stated R13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 7 should be turned and repositioned every two hours. R3's was not provided incontinence cares every two hours as directed by the care plan. R3's care plan identified on 2/11/15, a problem area for bowel status. The interventions directed staff to toilet R3 every night before bed, provide extensive assist with managing incontinence and perineal cares twice a day and after each incontinent episode. In addition, R3's care plan identified on 7/28/15, a problem area for urinary status and directed staff to provide extensive assist with incontinence episodes and to check and change R13's incontinent product every two hours. On 11/24/15, R3 was continuously observed from 7:10 a.m. until 10:13 a.m. (three hours and three minutes). During this time, R3 remained in her room lying on her back without personal care assistance. -At 7:21 a.m. dietary assistant (DA)-A entered R3's room and placed a breakfast tray on the over bed table and raised the head of the bed. DA-A lacked offering R3 toileting assistance. -At 10:13 a.m. NA-C knocked on the door, walked into room and took the breakfast tray from in front of R3. NA-C started a bed bath on R3, then opened R3's brief which was full of bowel movement and urine. On 11/24/15, at 1:50 p.m. RN-B and the DON confirmed it was their expectation for staff to	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 8 follow R3's care plan with regards to R3 being checked and changed every two hours as directed by R3's care plan. On 11/25/15, at 10:06 a.m. trained medication assistant (TMA)-A stated R3 should be checked and changed every two hours. R15's was not provided oral cares as directed by the care plan. R15's care plan dated 9/16/15, identified R15 had a deficit with self-care performance with activities of daily living (ADL's) and required extensive assist with personal hygiene cares and directed staff to provide mouth cares due to Gouty tophi (gout complications) on R15's hands. On 11/24/15, at 7:28 a.m. NA-A was observed to enter R15's room and proceed to complete R15's personal cares. NA-A was observed to bathe R15 in her bed, provide personal cares and dress her. NA-A utilized an over-head lift to transfer R15 to her wheelchair. NA-A combed her hair and then opened a denture dish and inserted R15's top plate into her mouth. R15's lips were observed dry with a thin line of white matter at the corners of her mouth. During this observation R15 was not offered or assisted with oral cares. -from 7:53 a.m. to 9:50 a.m. R15 was observed to consume breakfast and was assisted to the common activity area and situated at one of the tables. R15 was not offered or assisted with oral care.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 9 On 11/24/15, at 1:56 p.m. NA-A verified she did not provide R15 oral cares before or after breakfast. NA-A stated she usually used swabs and mouthwash to clean R15's mouth and she should have done that. On 11/24/15, at 2:17 p.m. RN-A stated R15 should have been provided oral cares as directed by the care plan. On 11/24/15 at 3:50 p.m. the DON stated R15 should have been provided or offered oral cares during morning cares. The DON confirmed R15's care plan was not followed. Comprehensive Care Plans policy dated 10/10, indicated each resident's care plan was designed to incorporate identified problem areas and the appropriate professional services responsible for each element of care. In addition, care plan interventions where to be designed to address the underlying sources of the problem areas identified. Care Plans policy (undated) indicated all residents would have a comprehensive care plan which described the services which were to be furnished to the resident so the resident's highest practicable physical, mental and psychosocial well-being would be attained and maintained. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to following the care plan. The DON or	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 10 designee, could provide training for all nursing staff related to the timeliness of care plan implementation. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper labeling of a wound cleansing product was maintained after staff had replaced the contents of the product's container with sterile water. This had the potential to affect residents (R5, R13, R38) who currently had wounds which required routine treatments.	2 830	Corrected	1/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 11 Findings include: R13's Physician Order Report dated 10/25/15 - 11/25/15, identified R13's diagnosis as having a chronic non-pressure ulcer to his calf. In addition, R13's dressing to this non-pressure related ulcer on the right calf was ordered to be changed twice a day. 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 (a first aid antiseptic spray with the active ingredient of Benzethonium chloride 0.13%) on the wound and removed the adhered 4 inch by 4 inch (4 x 4) 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 into the spray bottled labeled "dermal wound cleanser." TMA-B continued to spray the sterile water onto R13's wound and removed the remaining 4 x 4 gauze dressings and placed them in a nearby garbage. R13's right lateral lower leg stasis ulcer was visualized to be down to the bone; wound appeared raw and bloody with copious amounts of serosanguineous	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 12 (yellowish drainage with small amounts of blood) that had went through the 4 x 4 gauze dressings, ABD dressing (a sterile highly absorbent dressing) and the stockinet. On 11/20/15, this wound had measured 23.5 centimeters (cm) in length by 5.5 cm wide and 2.0 cm deep. TMA-B opened and placed three sterile packages of 4 x 4 gauze dressings and applied them to R13's wound. TMA-B placed an ABD dressing over the 4 x 4 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 gloves, cleaned up the supplies and washed his hands in the bathroom sink. TMA-B brought the bin of supplies (which included the spray bottle labeled dermal wound cleanser, however which contained sterile water) back to the medication drawer at the nursing station for others to use. On 11/24/15, at 1:24 p.m. TMA-B confirmed the spray bottled labeled "dermal wound cleanser" still contained sterile water. On 11/24/15, at 1:46 p.m. RN-B verified sterile water had been poured into the spray bottled labeled "dermal wound cleanser" and this container had not been tossed or relabeled. RN-B and the director of nursing (DON) confirmed this was not the facility's policy to do this and the bottle should have been tossed. No policy related to correct labeling of products or replacing the contents of a labeled bottle with another solution was provided.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 13 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring wound care products are labeled properly. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure all products are labeled properly. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify, assess and implement appropriate interventions for a resident	2 900	Corrected	1/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 14 who developed two stage II pressure related ulcers for 1 of 3 residents (R13) who developed two stage II pressure ulcers at the facility. This resulted in actual harm for R13. Findings include: R13's significant change Minimum Data Set (MDS) dated 8/24/15, indicated R13 had severe cognitive impairment, was frequently incontinent of bowel and bladder, required extensive assist with bed mobility, transferring, toileting and personal hygiene. In addition, R13 was identified as being at risk for pressure ulcer development, had existing venous and arterial ulcers and more than one pressure ulcer. Skin treatment included pressure reducing device in R13's chair and bed, turning and repositioning program and pressure ulcer care. R13's Care Area Assessment (CAA) dated 8/26/15, indicated R13 was at risk for skin impairment and had pressure ulcers and stasis ulcers noted. Factors for R13's care plan included provide assistance with cares and bed mobility, skin treatments as ordered, monitor skin integrity and report any reddened, irritated or open areas to the charge nurse, pressure relieving devices in chair and bed, encourage/remind resident to change position at least every two hours and weekly skin check by nursing staff. R13's Pressure Ulcer Healing Chart initiated on	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 healed on 10/16/15. R13 had been on an every one hour turning schedule from 8/28/15 - 9/25/15. R13' s care plan dated 9/2/15, identified skin integrity as a problem area. The interventions 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. The care plan also indicated on 4/25/15, R13 had right lower extremity stasis (vascular) ulcers and history of a stage two gluteal ulcer. In addition, the care plan indicated R13 was receiving hospice services. Hospice services directed staff to reposition R13 at least every two hours and when needed. R13's Physician Order Report dated 10/25/15 - 11/25/15, identified R13's diagnoses as chronic anemia, anxiety, chronic non-pressure ulcer to calf, dementia, heart failure and palliative care. The report also directed staff to reposition and/or offload (relieve pressure to area) R13 every two hours or more often and to avoid pressure to affected area. In addition, pressure and stasis ulcers should be measured and documented on weekly. R13's Braden Scale (tool used to asses a resident's level of risk for development of a pressure ulcer) dated 11/17/15, indicated R13 was at a high risk for development of a pressure ulcer. Interventions included bilateral heel	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 16 protectors, pressure relieving devices to chair and bed, every two hour turning/repositioning program, dressing changes and application of ointments. R13's Tissue Tolerance (assessment used to determine the skin's ability to withstand pressure without change) dated 11/18/15, indicated R13 should be placed on an every two hour turning/repositioning scheduled. 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 (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough), 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 bed to R13's wheelchair which had a pressure relieving cushion in its seat. -At 8:38 a.m. NA-B transported R13 out into the common area and positioned R13's wheelchair near the fire place. R13 had a blue foam boot on his right foot. -At 9:10 a.m. R13 complained of being cold and trained medication aide (TMA)-B retrieved another blanket and placed over R13's shoulders. R13 remained seated in his wheelchair in the	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 17 common area, until 10:10 a.m. when TMA-B transported R13 back to his room. -At 10:13 a.m. TMA-B with the assistance of registered nurse (RN)-B completed a dressing change to R13's right lower leg. R13 remained seated in the wheelchair during the dressing change. On 11/24/15, at 10:24 a.m. RN-B and TMA-B stated they were both unaware of any open areas on R13's buttocks. RN-B stated in the past R13 had had some open sores on the buttocks, but as far as RN-B was aware R13 did not have any current breakdown on his bottom now. -At 10:28 a.m. RN-B confirmed pressure ulcers were measured weekly during wound rounds. The weekly wound rounds were conducted by herself, the director of nursing (DON) and the other RN. RN-B verified the weekly wound assessments included measurements of the wound and documentation of the wounds on the Pressure Ulcer Healing Chart. On 11/24/15, at 10:40 a.m. (two hours and 25 minutes since R13 had last been repositioned) TMA-B and RN-B transferred R13 from the wheelchair back to R13's bed. RN-B removed R13's dry brief and confirmed R13 had two open areas on his buttocks and R13's bottom was reddened. TMA-B retrieved a measuring tape and RN-B measured both open areas. RN-B verified the pressure ulcer on the right side measured 0.7 cm in length x 0.6 cm in width and the pressure ulcer on the left measured 0.7 cm x 0.8 cm. RN-B confirmed both of these pressure ulcers where new.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 18 R13's weekly skin and pain assessment notes located in the resident progress note section of the electronic medical record indicated the following: · 11/5/15, assessment completed by TMA-B - stasis ulcer on right lateral lower leg; right great with black eschar (a dry dark scab); right lateral foot near the small toe had a darken scab, all other skin was in fair condition (no mention of any open areas on R13's buttocks) · 11/12/15, assessment completed by licensed practical nurse (LPN)-A indicated stasis ulcer on right lateral lower leg, right great toe and second toe black; right lateral foot near the small toe had a small eschar cap and a small area on his heel that had a darkened scab and one open area on buttocks (location of wound not specified nor a measurement or stage identified) * 11/16/15, hospice progress note completed by RN-D identified R13's lower right leg wound and foot wounds, however, failed to identify buttock wound. · 11/20/15, assessment completed by LPN-A indicated status ulcer on right lateral lower leg measured 23.5 cm x 5.5 cm x 2.0 cm; right great toe remained black; other toes on right foot have started to turn black; lateral right foot has eschar cap; back of the heel had opened and measured 3.5 cm x 2.0 cm; one open area on buttocks (location of wound not specified nor a measurement or stage identified). On 11/24/15, at 12:47 p.m. RN-B confirmed R13 was at risk for the development of a pressure ulcer. In addition, RN-B verified the aforementioned progress note dated 11/20/15, had indicated R13 had one open area on his buttock and stated she was not notified of the	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 19 new open area and the ulcer was not measured. On 11/24/15, at 12:52 p.m. RN-B confirmed both pressure ulcers on R13's buttocks were stage II pressure ulcers and even though it was hard to say, with the interventions in place R13's pressure ulcer could have been avoidable. RN-B stated anyone who had a current pressure ulcer should have been placed on an every one hour turning/repositioning schedule. RN-B stated R13 was now changed to an every one hour turning/repositioning schedule. R13's Pressure Ulcer Skin Note dated 11/24/15, verified R13 had two open areas on buttocks which measured: · right - 0.5 cm x 0.6 cm · left - 0.6 cm x 0.7 cm On 11/24/15, at 1:50 p.m. RN-B and the DON confirmed it was their expectation for staff to follow R13's care plan with regards to R13's turning and repositioning schedule and other pressure ulcer prevention interventions. On 11/25/15, at 9:08 a.m. NA-B stated R13 should be repositioned every two hours and if any breakdown was noticed, staff were to inform the medication nurse. NA-B was unaware that R13's turning/repositioning scheduled had been changed from every two hours to every one hour as stated by RN-B on 11/24/15, at 12:52 p.m. On 11/25/15, at 9:14 a.m. TMA-A stated R13 should be turned and repositioned every two	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 20 hours. TMA-A was unaware R13's turning/repositioning schedule had been changed from every two hours to every one hour as stated by RN-B on 11/24/15, at 12:52 p.m. R13's care plan provided on 11/25/15, by the DON failed to reflect the change from an every two hour repositioning/returning schedule to an every one hour repositioning/turning schedule as stated by RN-B on 11/24/15, at 12:52 p.m. The facility's Turning and Repositioning policy (undated) indicated residents would receive the necessary turning and repositioning to meet the specific needs to promote healing existing pressure ulcers, prevent reoccurrences of pressure ulcers and to prevent new pressure ulcer development. In addition, if a resident's skin was impaired related to a pressure ulcer, and once the area had healed, the resident would remain on a turning and repositioning schedule of every one hour for six months. The facility's Pressure Ulcer Assessment policy dated 2/25/11, indicated staff would document the notification/observation of any pressure ulcer immediately. Follow up documentation would be accomplished at least weekly or upon significant change in the ulcer area. In addition, tissue tolerance to pressure would be maintained and improved. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 21 they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with bowel and bladder incontinence cares for 1 of 3 residents (R3) reviewed for who requires assistance with incontinence cares. In addition, the facility failed to provide oral cares for 1 of 2 residents (R15) who required assistance with oral cares. Findings include:	2 920	Corrected	1/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 22 R3 was not provided incontinence care for over 3 hours on the morning of 11/24/15. R3's quarterly Minimum Data Set (MDS) dated 8/28/15, indicated R3 had moderate cognitive impairment, was frequently incontinent of bowel and bladder, had limited range of motion in the lower extremities bilaterally and required extensive assistance with bed mobility, transferring, toileting and personal hygiene. R3's Activity of Daily Living (ADL) Care Area Assessment (CAA) dated 3/4/15, indicated R3 was frequently incontinent of urine, required extensive assistance with toileting and was on an every two hour toileting program throughout the day. R3's care plan identified on 2/11/15, a problem area for bowel status and directed staff to toilet R3 every night before bed, provide extensive assist with managing incontinence and perineal cares twice a day and after each incontinence episode. In addition, R3's care plan identified on 7/28/15, a problem area for urinary status and directed staff to provide extensive assist with incontinence episodes and to check and change R13's incontinent brief every two hours. R3's bladder assessment dated 8/25/15, indicated R13 was frequently incontinent of bladder and that since R13 refused to use the toilet most of the time she had been switched to a check and change schedule throughout the day. R3's bowel assessment dated 8/25/15, indicated R13 was frequently incontinent of bowel and that	2 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 23 R13 had been changed to a check and change incontinence schedule. R3's Resident Admission Record printed on 11/25/15, indicated R3's diagnoses to include heart failure, depression, dysuria (painful or difficult urination) and constipation. On 11/24/15, R3 was continuously observed from 7:10 a.m. until 10:13 a.m. (three hours and three minutes). During this time, R3 remained in her room lying on her back. -At 7:21 a.m. dietary assistant (DA)-A entered R3's room and placed a breakfast tray on the over bed table and raised the head of the bed. DA-A lacked offering R3 toileting assistance. -At 10:13 a.m. nursing assistant (NA)-C knocked on R3's door, walked into room and took the breakfast tray from in front of R3. NA-C proceeded to start R3's bath. when NA-C opened R3's incontinent brief, the brief was full of bowel movement and urine. On 11/24/15, at 10:50 a.m. NA-C stated R3 was to be checked and incontinent brief changed and also repositioned every three hours. On 11/24/15, at 1:50 p.m. registered nurse (RN)-B and the director of nursing (DON) confirmed it was their expectation for staff to follow R3's care plan with regards to R3 being checked and changed every two hours. On 11/25/15, at 10:06 a.m. trained medication assistant (TMA)-A stated R3 should be checked	2 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 24 and changed every two hours. No policy related to incontinence care specific for checking and changing was provided. R15 was not provided oral care as directed by the care plan. R15's quarterly Minimum Data Set (MDS) dated 8/28/15, identified R15's diagnoses as depression and diabetes. The MDS also indicated R15 had moderate cognitive impairment and required extensive assist with personal hygiene cares. R15's care plan dated 9/16/15, identified R15 had a deficit with self-care performance with ADL's and required extensive assist with personal hygiene cares and directed staff to provide mouth cares due to Gouty tophi (gout complications) on R15's hands. On 11/24/15, at 7:28 a.m. NA-A was observed to enter R15's room and proceed to complete R15's personal cares. NA-A was observed to bathe R15 in her bed, provide personal cares and dress her. NA-A utilized an over-head lift to transfer R15 to her wheelchair. NA-A combed R15's hair, opened a denture dish and inserted R15's top plate into her mouth. R15's lips were observed dry with a thin line of white matter at the corners of her mouth. During this time R15 was not offered or assisted with oral cares.	2 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 25 On 11/24/15, from 7:53 a.m. to 9:50 a.m. R15 was observed to eat and finish her breakfast meal. Following breakfast, R15 was assisted to the common activity area and situated at one of the tables. During this time, R15 was not offered or assisted with oral care. On 11/24/15, at 1:56 p.m. NA-A verified she did not provide oral cares to R15 during morning cares or following the breakfast meal. NA-A stated she usually utilized swabs and mouthwash to clean R15's mouth and she should have done that. On 11/24/15, at 2:17 p.m. RN-A stated R15's oral cares should have been provided as R15 was on oxygen and her mouth got dry. On 11/24/15 at 3:50 p.m. the DON confirmed R15 should have had or been offered mouth care during morning cares. The facility, Oral hygiene policy (undated) indicated nursing staff would provide all residents with mouth care every morning, night and as needed. Care Plans policy (undated) indicated all residents would have a comprehensive care plan which described the services which were to be furnished to the resident so the resident's highest practicable physical, mental and psychosocial well-being would be attained and maintained.	2 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 26 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring incontinence and oral care is provided for each individual resident . The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand washing technique was performed during wound care for 2 of 2 residents (R5, R13) observed during dressing change. Findings include: R5 was observed to receive wound care and the staff member failed to perform appropriate hand washing during the provision of the treatment. On 11/25/15, at 7:54 a.m. registered nurse	21375	Corrected	1/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 27	21375		

(RN)-A was observed to approach R5 while he was seated in a wheelchair in his room. RN-A removed R5's foam boot, sock and peeled back the transparent dressing covering a wound on the left heel. RN-A was not wearing gloves when she removed the old dressing. The wound was observed to be a thick black scab (eschar) and was not draining. RN-A measured the wound to be 2.0 centimeters (cm) by 1.3 cm. RN-A left the room to gather additional dressing supplies. She approached the medication nurse and asked for additional dressing supplies. RN-A was not observed to wash her hands prior to leaving the room. RN-A then returned to the room, applied a betadine solution to the wound and covered the wound with the old dressing. RN-A was not observed to wear gloves during the procedure. RN-A then applied R5's sock and replaced the foam boot. At 8:00 a.m. RN-A opened the door, left the room and walked to the neighborhood kitchenette and washed her hands.

On 11/25/15, at 8:05 a.m. RN-A verified she had not worn gloves during the dressing change nor had she washed her hands during the procedure. She verified gloves should have been worn during the procedure.

R13 was observed to receive wound care and the staff member failed to perform appropriate hand washing during the provision of the treatment.

R13's Physician Order Report dated 10/25/15 - 11/25/15, identified R13's diagnoses as anemia, anxiety, chronic non-pressure ulcer to calf, dementia, heart failure and hypertension. In addition, R13's dressing to the non-pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 28 related ulcer on the right calf was ordered to be changed twice a day. 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 on the wound and removed the adhered 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 into the spray bottled labeled "dermal wound cleanser." TMA-B continued to spray 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 (yellowish drainage with small 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 gloves, cleaned up the supplies and washed his hands in the bathroom sink.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 29 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, mucous 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 glove 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 again and a clean pair of gloves donned; the wound should be cleansed and new clean dressings applied; gloves should be removed and hands washed and dried following completion of the dressing	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 30 change. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review infection control practices during wound care and educate staff. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented in order to reduce the risk of infection. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21510	MN Rule 4658.1200 Subp. 2 A.B. SpecializedRehabilitative Services; Provision Subp. 2. Provision of services. If specialized rehabilitative services are required in the resident's comprehensive plan of care, the nursing home must: A. provide the required services; or obtain the required services from an outside source according to part 4658.0075. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a level II Preadmission Screening and Resident Review (PASRR) was completed for 1 of 1 resident (R58) who was assessed with intellectual disabilities. Findings include:	21510	Corrected	1/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21510	Continued From page 31 R58's hospital consult note dated 10/27/15, from Sanford Medical Center Fargo indicated R58's diagnoses included Prader-Willi (rare genetic disorder characterized by cognitive disabilities and chronic feeling of hunger), developmentally delayed and anxiety. R58 had resided in a group home prior to her admission to the hospital. R58's Progress note dated 11/6/15, indicated R58 was disabled and required extensive assist with transfers and toileting. R58's The Pre-Admission Screening Assessment (PAS/OBRA Level I) dated 11/5/15, indicated a Level II Developmental Disability Evaluation and final review of the need for specialized services was required by placing a check mark next to the statement of such. On 11/23/15, at 12:54 p.m. a late entry for 11/20/15, had been entered into R58's resident progress notes by licensed social worker (LSW)-A. This note indicated a message had been left with Norman county social services (NCSS) for an update on the level II PASRR screening for R58. On 11/23/15, at 3:10 p.m. R58 was observed participating in the chair yoga activity in the common area. On 11/23/15, at 7:02 p.m. R58 was seated in the common area in her wheelchair where she ate a snack and conversed with staff and other residents.	21510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21510	Continued From page 32 On 11/24/15, at 9:03 a.m. a late entry for 11/23/15, had been entered into R58's resident progress notes by LSW-A indicating another message had been left with NCSS regarding the PASRR screening for R58. R58's progress note dated 11/24/15, at 9:53 a.m. indicated LSW-A had contacted NCSS and the NCSS representative had confirmed the level II PASRR screening hadn't been completed and she was going to check with her supervisor. On 11/24/15, at 11:30 a.m. R58 was observed in the rehabilitation department participating in a therapy session. On 11/25/15, at 8:23 a.m. LSW-A confirmed R58's level II PASRR screening had not been completed. LSW-A stated she thought the county had ten days to complete this screening. LSW-A stated the county representative had informed her there had been a miscommunication and the level II PASRR screening for R58 had been missed. At this time, LSW-A was unaware of when the screening would be completed. On 11/25/15, at 9:30 a.m. R58 was observed in the dining room eating her breakfast. R58 stated she used to have a job at the occupational development center (ODC) where she placed labels on papers and also put papers in a shredder machine. R58 stated she missed her job.	21510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21510	Continued From page 33 The Admission Prescreening for Individuals with Mental Retardation or Mental Illness dated 4/12, indicated a nursing facility was not to admit any resident with an intellectual or developmental disability until authority had determined prior to admission that the individual required that level of service provided by the facility and whether or not the individual required specialized services. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring PASAR screenings are completed for newly admitted residents. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure newly admitted residents recieve the required screenings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21510		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change.	21530		1/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 34 B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the pharmacist identified the lack of target behaviors and non pharmacological interventions to be attempted prior to the administration of an as needed (PRN) anti-anxiety medication for 1 of 1 resident (R49) who received anti-anxiety medications without the aforementioned identified. In addition the pharmacist failed to identify the lack of sleep pattern monitoring for 1 of 1 resident (R5) who	21530	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 35 received hypnotic medications. Findings include: R49 received PRN lorazepam (antianxiety medicaiton) without target behaviors for the use of the medication identified nor non pharmacological interventions to be attempted prior to the administration of the medication. R49's admission Minimum Data Set (MDS) dated 8/31/15, indicated R49 had severe cognitive impairment, showed no signs of psychosis or behavior towards self or others. In addition, R49 had received one dose of PRN antianxiety medication during the seven day observation period of this assessment. R49's psychotropic medication use Care Area Assessment (CAA) dated 8/31/15, indicated R49 was at risk for side effects due to the use of an antianxiety medication. The CAA lacked identification of target behaviors and nonpharmacological interventions to be implemented prior to the administration of the antianxiety medication. R49's Physician Order Report dated 10/25/15-11/25/15, indicated R49 had diagnoses that included chronic obstructive pulmonary disease, anxiety disorder, heart failure and dementia. In addition, on 8/18/15, the physician had ordered lorazepam 0.5 milligrams (mg) that could be given PRN up to three times a day for generalized anxiety. However, the order had not	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 36 identified specific target behaviors for the use of the PRN lorazepam. R49's care plan identified on 8/18/15, a problem area for psychotropic medication use. The interventions directed staff to monitor for side effects of the psychotropic medication and for the physician and pharmacist review to be conducted per guidelines for gradual dose reduction. R49's care plan lacked identification of target behaviors for the use of the PRN lorazepam and nonpharmacological interventions to be attempted prior to the administration of the antianxiety medication. R49's informed consent for psychotropic medications dated 1/17/15, listed lorazepam 0.5 mg PRN up to two times a day for anxiety. The section of the consent form which requested that target behaviors to be noted in specific terms, lacked identification of target behaviors for the use of the lorazepam. R49's PRN Medications Administration History dated 9/1/15 - 11/25/15, indicated R49 had received lorazepam 0.5 mg on 9/13/15, 9/14/15, 9/24/15, 10/5/15, 10/19/15, and 10/29/15. The lorazepam 0.5 mg had been administered for a variety of reasons such as picking her nose, self-transferring, restlessness, and yelling out. R49's medical record lacked documentation with regards to nonpharmacological interventions attempted prior to the administration of the lorazepam on 9/13/14, 9/14/15, and 10/29/15. Review of the pharmacists monthly medication	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 37 review for R49, from 8/23/15 - 11/5/15, lacked mention of the need for the identification of target behaviors and nonpharmacological interventions for the utilization of R49's PRN lorazepam. On 11/24/15, at 3:43 p.m. registered nurse (RN)-B confirmed target behaviors and nonpharmacological interventions had not been specifically identified or consistently documented for the utilization of the PRN lorazepam for R49. RN-B stated the licensed social worker (LSW)-A usually developed the psychotropic portion of the care plan which would list the target behaviors and nonpharmacological interventions. On 11/24/15, at 4:10 p.m. the consulting pharmacist (CP) confirmed target behaviors and nonpharmacological interventions should have been identified and consistently utilized for R49's PRN use of the lorazepam. The CP stated she tried to make sure these were identified and documented as part of the monthly pharmacy medication regime reviews. On 11/25/15, at 8:30 a.m. LSW-A confirmed target behaviors and nonpharmacological interventions had not been specifically identified for the R49's PRN use of the lorazepam. No policy on the development and implementation of target behaviors and nonpharmacological interventions was provided. R5's clinical record lacked sleep pattern monitoring for the continued use of a hypnotic medication.	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 38 R5's quarterly MDS dated 8/23/15, indicated R5 was diagnosed with diabetes, a stroke and insomnia. The MDS also indicated R5 had intact cognition and required extensive assistance with bed mobility, transfers and was unable to ambulate. R5's current Physicians orders included an order started on 11/28/14, for Zaleplon (hypnotic medication). The orders indicated the medication was decreased to 10 mg at bedtime on 11/6/15. The orders also directed staff to chart R5's sleeping behavior and pattern if it had improved or not. R5's care plan dated 12/22/14, directed staff to administer Zaleplon for insomnia and monitor for side effects. R5's Progress Note dated 11/6/15, indicated R5 had been evaluated by the psychiatrist and the Zaleplon was decreased to 10 mg at bedtime as it may cause an increase in sleep apnea. R5's Physician clinic notes dated 11/12/15, indicated R5 had not been sleeping well and was frequently up throughout the night. R5 had displayed irritability towards the staff and aggressive behaviors. A sleep study was ordered at that time. R5's clinical record lacked any indication of sleep pattern monitoring and / or documentation.	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 39 On 11/24/15, at 12:24 p.m. RN-A stated R5 had difficulty sleeping and a sleep study had been scheduled for December 2015. She stated the nurses were to be documenting his sleep pattern since the hypnotic medication had just been reduced on 11/6/15. RN-A then reviewed R5's progress notes and confirmed the facility had not documented on R5's sleep pattern since his medication dose had been changed. On 11/24/15, at 3:50 p.m. R5 stated he routinely went to bed around 6:00 p.m. He stated he only slept well when he took the medications. Review of the pharmacist Progress Notes indicated R5 was receiving Zaleplon 15 mg at bedtime on 5/7/15. The pharmacist note dated 11/5/15, indicated the Zaleplon had been reduced and the staff were to continue to monitor sleep. However, the clinical record lacked documentation related to sleep pattern monitoring. On 11/24/15, at 4:10 p.m. the CP stated she had identified the Zaleplon 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	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 40 each client for the continued need for the medication. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services,	21535		1/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 41 Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to identify target behaviors and identify and implement non pharmacological interventions for 1 of 1 resident (R49) who received an as needed (PRN) anti-anxiety medication. In addition, the facility failed to monitor the sleep pattern for the use of hypnotic medication for 1 of 1 resident (R5) who received a hypnotic, had a dose change and lacked documentation related to the effectiveness of the medication. Findings include: R49 received PRN lorazepam (antianxiety medication) and target behaviors and nonpharmacological interventions had not been identified or consistently implemented. R49's admission Minimum Data Set dated 8/31/15, indicated R49 had severe cognitive impairment, showed no signs of psychosis or behavior towards self or others. In addition, R49 had received one dose of PRN antianxiety medication during the seven day observation period of this assessment.	21535	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 42 R49's Psychotropic Medication Use Care Area Assessment (CAA) dated 8/31/15, indicated R49 was at risk for side effects due to the use of an antianxiety medication. The CAA lacked identification of target behaviors and nonpharmacological interventions to be implemented prior to the administration of the antianxiety medication. R49's care plan identified on 8/18/15, a problem area for psychotropic medication use. The interventions directed staff to monitor for side effects of the psychotropic medication and for the physician and pharmacist review to be conducted per guidelines for gradual dose reduction. R49's care plan lacked identification of target behaviors for the use of the PRN lorazepam and nonpharmacological interventions to be attempted prior to the administration of the antianxiety medication. R49's Physician Order Report dated 10/25/15-11/25/15, indicated R49 had diagnoses that included chronic obstructive pulmonary disease, anxiety disorder, heart failure and dementia. In addition, on 8/18/15, the physician had ordered lorazepam 0.5 milligrams (mg) that could be given PRN up to three times a day for generalized anxiety. However, the order had not identified specific target behaviors for the use of the PRN lorazepam. R49's informed consent for psychotropic medications dated 1/17/15, listed lorazepam 0.5 mg PRN up to two times a day for anxiety. The section of the consent form which requested that target behaviors be noted in specific terms,	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 43 lacked identification of target behaviors for the use of the lorazepam. R49's PRN Medications Administration History dated 9/1/15 - 11/25/15, indicated R49 had received lorazepam 0.5 mg on 9/13/15, 9/14/15, 9/24/15, 10/5/15, 10/19/15, and 10/29/15. The lorazepam 0.5 mg had been administered for a variety of reasons such as picking her nose, self-transferring, restlessness and yelling out. R49's medical record lacked documentation with regards to nonpharmacological interventions attempted prior to the administration of the lorazepam on 9/13/14, 9/14/15, and 10/29/15. On 11/24/15, at 9:31 a.m. R49 was observed in the dining room, seated in her wheelchair. R49 is well groomed, has oxygen on and eating her breakfast independently. On 11/24/15, at 9:58 a.m. R49 was observed seated in a recliner by the fireplace in the common area. R49 had her feet elevated, oxygen on and eyes closed. On 11/24/15, at 3:40 p.m. trained medication aide (TMA)-B stated R49 received the PRN lorazepam when R49 attempted to self-transfer because she wanted to get up and go to the bathroom. TMA-B confirmed R49 lacked identification of nonpharmacological interventions to be attempted prior to the administration of the PRN lorazepam. TMA-B stated they just would try different things.	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 44 On 11/24/15, at 3:43 p.m. registered nurse (RN)-B confirmed target behaviors and nonpharmacological interventions had not been specifically identified or consistently documented for the utilization of the PRN lorazepam for R49. RN-B stated the licensed social worker (LSW)-A usually developed the psychotropic portion of the care plan which would list the target behaviors and nonpharmacological interventions. On 11/24/15, at 4:10 p.m. the consulting pharmacist (CP) stated target behaviors and nonpharmacological interventions should have been identified and consistently utilized for R49's PRN use of the lorazepam. On 11/25/15, at 8:30 a.m. LSW-A confirmed target behaviors and nonpharmacological interventions had not been specifically identified for R49's PRN use of the lorazepam. No policy on the development and implementation of target behaviors and nonpharmacological interventions was provided. R5's clinical record lacked sleep pattern monitoring for the continued use of a hypnotic medication. R5's quarterly MDS dated 8/23/15, indicated R5 was diagnosed with diabetes, a stroke and insomnia. The MDS also indicated R5 had intact cognition and required extensive assistance with bed mobility, transfers and was unable to	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 45 ambulate. R5's current Physicians orders included an order started on 11/28/14, for Zaleplon (hypnotic medication). The orders indicated the medication was decreased to 10 milligrams at bedtime on 11/6/15. The orders also directed staff to chart R5's sleeping behavior and pattern if it had improved or not. R5's care plan dated 12/22/14, directed staff to administer Zaleplon for insomnia and monitor for side effects. R5's Progress Note dated 11/6/15, indicated R5 had been evaluated by the psychiatrist and the Zaleplon was decreased to 10 mg at bedtime as it may cause an increase in sleep apnea. R5's Physician clinic notes dated 11/12/15, indicated R5 had not been sleeping well and was frequently up throughout the night. R5 had displayed irritability towards the staff and aggressive behaviors. A sleep study was ordered at that time. R5's clinical record lacked any indication of sleep pattern monitoring and / or documentation. On 11/24/15, at 12:24 p.m. RN-A stated R5 had difficulty sleeping and a sleep study had been scheduled for December 2015. She stated the nurses were to be documenting his sleep pattern since the hypnotic medication had just been	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 46 reduced on 11/6/15. RN-A then reviewed R5's progress notes / clinical record and confirmed the facility had not documented on R5's sleep patter since his medication dose had been changed. On 11/24/15, at 3:50 p.m. R5 stated he routinely went to bed around 6:00 p.m. He stated he only slept well when he took the medications. A policy regarding medication monitoring was requested and none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring medication regimen review. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure residents are not receiving unnecessary medications. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings.	21695		1/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 47 This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure wheelchair armrests were maintained in a clean, safe and sanitary condition for 3 of 3 residents (R49, R56, R7) who had torn, loose or uncleanable arm rests. Findings include: On 11/23/15, at 2:32 p.m. R49's right wheelchair arm rest was observed very loose, wobbly. On 11/23/15, at 3:13 p.m. R56's wheelchair arm rests were observed uncovered with padding exposed. On 11/23/15, at 5:29 p.m. R7 was observed seated in the wheelchair. R7's wheelchair arm rests were observed torn and cracked. On 11/24/15, at 12:45 p.m. the Environmental Director (ED) observed the aforementioned wheelchairs and verified R49's right wheelchair arm rest was missing screws and coming apart and stated it would be fixed. The ED verified R56's arm rests were uncovered with exposed, uncleanable padding and they would be replaced. In addition, the ED verified R7's arm rests were torn / cracked with exposed padding, uncleanable and in need of repair. The ED stated they would be replaced. -At 1:00 p.m. the ED stated the facility did not have a maintenance schedule specific for the monitoring of the wheelchair arm rest rather, the	21695	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 48 nursing staff were directed to submit a work order to maintenance when a wheelchair was in need of repair or replacement. The ED stated the facility did not have a policy and procedure related to the maintenance of wheelchairs / arm rests. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance reporting resident equipment repair need. The DON or designee, could coordinate with maintenance and nursing staff to conduct periodic audits of resident wheelchairs to ensure needed repairs are provided. The DON or designee could forward audits to the QA committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21840	MN St. Statute 144.651 Subd. 12 Patients & Residents of HC Fac.Bill of Rights Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in	21840		1/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21840	Continued From page 49 the resident's medical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a resident at risk for pressure ulcers was provided education related to the risk versus (vs) benefits of refusing repositioning assistance for 1 of 1 resident (R5) observed with a current stage four ulcer and refused repositioning assistance. Findings include: R5's quarterly Minimum Data Set (MDS) dated 8/23/15, indicated R5 was diagnosed with diabetes, history of a stroke and was at risk for the development of pressure ulcers. The MDS also indicated R5 had intact cognition, required extensive assistance with bed mobility, transfers and was unable to ambulate. R5's Pressure Ulcer Care Area Assessment (CAA) dated 2/20/15, indicated R5 was at risk for the development of pressure ulcers due to need for assistance with mobility, transfers and history of incontinence. The CAA also indicated R5 had a history of peripheral artery disease, edema and neuropathy in his lower extremities. The assessment directed staff to utilize a pressure redistribution cushion on his wheelchair and to utilize specialized booties on his feet. R5's care plan dated 3/9/15, directed staff to ensure R5 utilized a diabetic shoe on the left foot	21840	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21840	Continued From page 50 when up in the chair and Prevalon (foam) boot on the left foot when in bed. R5 was to utilize a Holister heel, lift boot (formed boot) on the right foot in bed and a Prevalon boot on the right foot when in the wheelchair. The care plan directed staff to assist R5 to reposition every two hours. R5's Braden Scale (tool utilized to identify pressure ulcer risk) dated 11/17/15, indicated R5 was at moderate risk for the development of pressure ulcer. R5's Progress Notes dated 11/6/15, indicated R5 had developed a patch of black eschar (thick scab/dead tissue) on his left heel which measured 2.1 centimeters (cm) by 1.5 cm. R5's Progress Note dated 11/21/15, indicated the wound was still present on R5's left heel. On 11/24/15, at 7:15 a.m. R5 was observed in the dining room, seated in a wheelchair. R5 was continuously observed from 7:30 a.m. until 10:30 a.m. -At 7:31 a.m. R5 wheeled from the dining room to his room where he turned on the television. -At 8:20 a.m. nursing assistant (NA)-D offered to reposition R5 but he refused. -At 9:22 a.m. NA-D returned to the room and R5 refused assistance. -At 9:50 a.m. NA-E stated R5 frequently refused assistance during the day. She stated R5 had not allowed the day shift staff to assist him since they had arrived at the facility at 6:00 a.m. -At 10:00 a.m. NA-D stated she had been in to visit R5 twice and he had refused cares each	21840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21840	Continued From page 51	21840		

time. She stated the night staff had assisted R5 into the wheelchair before 6:00 a.m. and he had not accepted assistance with repositioning since that time.
-At 10:15 a.m. R5 was observed to be transferred with a ceiling lift (full body lift attached to the ceiling) from the wheelchair to the toilet. R5's wheelchair was observed equipped with a pressure redistribution cushion. R5's buttocks was observed pink with the skin intact. R5's feet were observed to be covered with bilateral Prevalon boots. NA-D confirmed R5 had been in the wheelchair for greater than 4 hours and 15 minutes and had refused assistance with repositioning.

Review of R5's clinical record lacked documentation indicating the risk vs benefits of repositioning / refusal to repositioned in relationship to pressure ulcer prevention.

On 11/24/15, at 12:40 a.m. registered nurse (RN)-A stated R5's left heel was noted to have an area of concern on 10/27/15. She stated the heel was soft and had an area of 1.8 cm x 2.1 cm but it was intact. She stated at that time, R5's Holister boots were removed and the Prevalon boots were implemented. She explained R5 had a long history of refusing care from staff members and she had talked to him the past about refusals but had not documented the identified concern.

On 11/24/15, at 3:40 p.m. the director of nursing stated staff should have discussed the risk vs benefits of refusal of care with R5 and documented those concerns in the clinical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21840	Continued From page 52 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 left 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. The Refusal of Treatment policy dated 2/2014, indicated any time a resident refused treatment, the staff were to document the residents refusal, how the resident was informed of the purpose of the treatment and the consequences of not receiving the treatment, physician notification of refusals and alternative approaches attempted to encourage the resident to comply with treatment. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to resident's rights to refuse treatment after having been educated to potential risks. The DON could develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21840		