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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7SEX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00314

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245360**

2.STATE VENDOR OR MEDICAID NO.
(L2) **770057500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY OF NEW LONDON**
(L4) **100 GLEN OAKS DRIVE**
(L5) **NEW LONDON, MN** (L6) **56273**

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) **02/01/2011**

6. DATE OF SURVEY **01/30/2015** (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)
12/31

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

12.Total Facility Beds **58** (L18)

13.Total Certified Beds **58** (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
	58			
(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):
Mandatory DOPNA, effective 02/06/15, is discontinued effective 01/21/15.

17. SURVEYOR SIGNATURE Date :
Bruce Melchert, HFE NE II 01/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 03/12/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(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: **00** (L30)
VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/13/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/23/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245360

March 12, 2015

Mr. James Ingersoll, Administrator
Benedictine Living Community of New London
100 Glen Oaks Drive
New London, Minnesota 56273

Dear Mr. Ingersoll:

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 the above facility is certified for or recommended for:

58 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 58 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,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 4, 2015

Mr. James Ingersoll, Administrator
Benedictine Living Community Of New London
100 Glen Oaks Drive
New London, Minnesota 56273

RE: Project Number S5360026

Dear Mr. Ingersoll:

On January 13, 2015, we informed you that the following enforcement remedy was being imposed:

> **• Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 6, 2015. (42 CFR 488.417 (b))**

Also, we notified you in our letter of January 13, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 6, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on November 6, 2014, and lack of verification of substantial compliance with the health deficiencies at the time of our January 13, 2015 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On January 30, 2015, 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 6, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 21, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 6, 2014, as of January 21, 2015.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of January 13, 2015. The CMS Region V Office concurs and has authorized this Department to

notify you of these actions:

- **Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 6, 2015, be rescinded. (42 CFR 488.417 (b))**

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective February 6, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective February 6, 2015, is to be rescinded.

In our letter of January 13, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 6, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 21, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245360	A. Building B. Wing	1/30/2015

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0312 Reg. # 483.25(a)(3) LSC	01/21/2015	ID Prefix F0441 Reg. # 483.65 LSC	01/21/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By BF/KJ	Date: 3/12/2015	Signature of Surveyor: 32613	Date: 3/12/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 11/6/2014		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: 7SEX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00314

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245360**
2.STATE VENDOR OR MEDICAID NO.
(L2) **770057500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY OF NEW LONDON**
(L4) **100 GLEN OAKS DRIVE**
(L5) **NEW LONDON, MN** (L6) **56273**

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) **02/01/2011**

6. DATE OF SURVEY 12/31/2014 (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **58** (L18)

13.Total Certified Beds **58** (L17)

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

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
	58			
(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):
Mandatory DOPNA, effective 02/06/15, is recommended.

17. SURVEYOR SIGNATURE — Date :
Bruce Melchert, HFE NE II 01/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 03/12/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(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: **00** (L30)
VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/13/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/23/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 13, 2015

Mr. James Ingersoll, , Administrator
Benedictine Living Community Of New London
100 Glen Oaks Drive
New London, Minnesota 56273

RE: Project Number S5360026

Dear Mr. Ingersoll:

On November 21, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 6, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 31, 2014, the Minnesota Department of Health and on December 8, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 6, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 22, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on November 6, 2014. The deficiency(ies) not corrected is/are as follows:

F0312 -- S/S: D -- 483.25(a)(3) -- Adl Care Provided For Dependent Residents
F0441 -- S/S: D -- 483.65 -- Infection Control, Prevent Spread, Linens

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective January 17, 2015. (42 CFR 488.422)

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 6, 2015.

(42 CFR 488.417 (b))

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Benedictine Living Community of New London is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 6, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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:

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

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 remedy be imposed:

• 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a 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 allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 6, 2015 (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 6, 2015 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	R 12/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(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 census 43 census 43	{F 000}		
{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 oral hygiene for 1 of 3 residents (R50) reviewed for oral care. Findings include: R50's diagnoses from the Care Plan edited 9/10/14, included Dementia w/Lewy bodies, aphasia (loss of ability to understand/express speech) related to a cerebral vascular accident (CVA), and Parkinson's Disease. The quarterly Minimum Data Set (MDS) dated 11/29/14, indicated R50 required extensive assistance with dressing, toileting and personal hygiene. Review of R50's care plan, edited 9/10/14, indicated that R50 required extensive assistance with all of her activities of daily living, and R50 had her own teeth. The care plan directed staff to assist with oral cares twice a day (BID) and as needed (PRN). On 12/30/14 at 8:19 a.m., nursing assistant	{F 312}	a., b., c., All residents that require assist with personal hygiene tasks could be affected by this practice. To prevent this from recurring the orientation checklist has been modified for contracted staff including education tools related to basic infection control; electronic medical record, including how to access each resident□s individualized care plan; quality standards with clear and concise direction related to expectations for care for all dependent residents; assignment of a mailbox for memos and other communication tools. Nursing staff have been re-educated about the importance of providing assistance with oral cares with AM and PM cares and proper technique for completion. d. Monitoring of correct oral care completion for 10% of facility population will be biweekly x 1 month, then quarterly throughout the following year, with results	1/21/15

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

Electronically Signed | 01/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	R 12/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(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 1 (NA)-A was observed providing morning cares to R50. At no time during observation of morning cares did NA-A offer or perform oral cares for R50. When asked if there was anything else to do for R50 's morning cares, NA-A replied, "No." NA-A then wheeled R50 to the dining room. NA-A did not identify oral cares as part of morning cares. During interview on 12/30/2014 at 9:49 a.m., NA-A said she had not seen a tooth brush in R50's room. NA-A said she used the edge of white hand towel to wipe R50's teeth and has not seen written directions about brushing R50's teeth. Observation of R50's private bathroom on 12/30/14 at 12:00 p.m. revealed two toothbrushes and toothpaste on the bathroom counter in an emesis basin. During interview on 12/30/14 at approximately 12:15 p.m., registered nurse (RN)-B stated the NA worksheet is where an aide would look for directions on oral cares for residents. On 12/30/14 at 12:30 p.m., the director of nursing (DON) stated individualized oral care directions were listed on the care plan which is found in the electronic record and accessible to all NA's. Upon further interview on 12/30/14 at 2:30 p.m., the DON indicated oral hygiene should be offered at least during morning and evening cares. She further stated oral care is to be individualized offering a tooth brush or toothette; residents are to brush as able, or staff will assist; dentures are to be cleaned and water offered to rinse and mouthwash is to be offered if the resident is able. The DON confirmed using a washcloth to wipe a resident's teeth was not appropriate.	{F 312}	reported to the Quality Council, by Director of Nursing or designee. If contracted staff are present during the auditing period, their cares will be observed to ensure correct completion of oral care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	R 12/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(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 2 12/30/14 review of the NA Worksheet did not indicate if R50 has her own teeth or dentures. The worksheet lacked direction for R50's oral cares.	{F 312}		
{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 (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.	{F 441}		1/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	R 12/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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{F 441}	Continued From page 3 (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 proper hand hygiene was maintained during personal cares for 1 of 3 residents (R50) reviewed for personal cares. Findings include: R50's diagnoses from the Care Plan edited 9/10/14, included Dementia w/Lewy bodies, aphasia (loss of ability to understand/express speech) related to a cerebral vascular accident (CVA), and Parkinson's Disease. The quarterly Minimum Data Set (MDS) dated 11/29/14, indicated R50 required extensive assistance with dressing, toileting and personal hygiene. On 12/30/14 at 8:19 a.m., nursing assistant (NA)-A donned a pair of gloves from her uniform pocket. NA-A moved the fall mat and wheelchair, went to the closet for clothes, and laid the clothes and clean incontinence product on a chair along with a washcloth and a towel. NA-A initiated cares for R50. NA-A used a walkie-talkie to ask for transfer assistance. NA-A removed R50's soiled incontinence product and placed it in the garbage can. With the same gloved hands, NA-A went to the sink and returned with a wash cloth, towel and	{F 441}	All residents that require assist with personal hygiene tasks could be affected by this practice. To prevent this from recurring the orientation checklist has been modified for contracted staff including education tools related to basic infection control; electronic medical record, including how to access each resident□s individualized care plan; quality standards with clear and concise direction related to expectations for care for all dependent residents; assignment of a mailbox for memos and other communication tools. Nursing staff have been re-educated about proper use of standard precautions at all times, including, but not limited to when to perform hand hygiene, change gloves, not handling equipment with soiled gloves, etc. d., Audits of proper use of standard precautions will be performed weekly for 1 month; biweekly for 1 month, then quarterly throughout the following year, with results reported to the Quality Council, by Director of Nursing or designee. If contracted staff are present during the auditing period, their cares will be observed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	R 12/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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{F 441}	Continued From page 4	{F 441}		

pink basin filled with water. NA-A washed and dried R50's front perineal area.

NA-F entered the room to assist with R50. NA-F donned gloves. NA-A and NA-F rolled R50 to the side and NA-A washed R50's posterior perineal area. The NA's then put a new incontinence product on R50 and assisted her to sit on the edge of the bed. With the soiled gloves on, NA-A pulled the EZ stand (a mechanical lift used to assist with transfers) to the bedside by the handles, buckled R50 into the EZ stand and transferred R50 to the wheelchair. NA-F removed the gloves and exited the room pushing the EZ stand by the handles. NA-F did not wash or sanitize hands after removing the gloves and prior to exiting the room.

NA-A took the pink basin and washcloth to the bathroom and dumped the water into the sink. Without cleaning or sanitizing, NA-A refilled the same pink basin that was used to wash the front and posterior perineal areas with R50. NA-A brought the basin filled with water to R50 and assisted her with washing her face. NA-A washed R50's torso and under arms and returned the basin and washcloth to the bathroom. NA-A put lotion on R50's back, put on her sweatshirt and combed her hair. NA-A picked up the dirty linens from the bedside table. NA-A then removed the soiled gloves, put them in the garbage can and knotted the plastic garbage can liner, dropping it on the floor. NA-A picked up R50's glasses, put them on her face; picked up the bag of garbage and soiled linen and wheeled R50 to the hallway. When asked if there was anything else to do for R50's morning cares, the NA replied, "No." NA-A continued down the hall to the soiled linen room, and using the door handle to enter,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	R 12/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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{F 441}	Continued From page 5	{F 441}		

disposed of the linen and garbage. Upon her return to the hallway outside R50's room, NA-A stated she should probably sanitize her hands. For the first time since initiating the observation, NA-A sanitized her hands.

On 12/30/14 at 9:49 a.m., NA-A verified she put on a pair of gloves when entering R50's room and did not wash or sanitize hands with cares or upon leaving room. NA-A agreed she washed R50's private areas and later washed R50's face wearing the same gloves.

The facility's standard precautions policy dated 6/2002 specified:

· Change gloves between residents and as necessary (i.e. torn or contaminated.) DO NOT use contaminated gloves on clean areas. Always work clean to dirty.

· Linen is to be handled, transported and processes in a manner that prevents exposure and contamination of clothing and avoid transfer of microorganisms to other residents and the environment. The policy further specified soiled linen should be handled with gloves.

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245360	A. Building B. Wing **01 - MAIN BUILDING 01**	12/8/2014

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0144	Correction Completed **11/14/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KJ/PS	1/12/2015	34764	12/8/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
11/5/2014		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	R 12/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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{F 000}	INITIAL COMMENTS census 43 census 43	{F 000}		
{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 oral hygiene for 1 of 3 residents (R50) reviewed for oral care. Findings include: R50's diagnoses from the Care Plan edited 9/10/14, included Dementia w/Lewy bodies, aphasia (loss of ability to understand/express speech) related to a cerebral vascular accident (CVA), and Parkinson's Disease. The quarterly Minimum Data Set (MDS) dated 11/29/14, indicated R50 required extensive assistance with dressing, toileting and personal hygiene. Review of R50's care plan, edited 9/10/14, indicated that R50 required extensive assistance with all of her activities of daily living, and R50 had her own teeth. The care plan directed staff to assist with oral cares twice a day (BID) and as needed (PRN). On 12/30/14 at 8:19 a.m., nursing assistant	{F 312}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 312}	Continued From page 1	{F 312}		

(NA)-A was observed providing morning cares to R50. At no time during observation of morning cares did NA-A offer or perform oral cares for R50. When asked if there was anything else to do for R50 's morning cares, NA-A replied, "No." NA-A then wheeled R50 to the dining room. NA-A did not identify oral cares as part of morning cares.

During interview on 12/30/2014 at 9:49 a.m., NA-A said she had not seen a tooth brush in R50's room. NA-A said she used the edge of white hand towel to wipe R50's teeth and has not seen written directions about brushing R50's teeth.

Observation of R50's private bathroom on 12/30/14 at 12:00 p.m. revealed two toothbrushes and toothpaste on the bathroom counter in an emesis basin.

During interview on 12/30/14 at approximately 12:15 p.m., registered nurse (RN)-B stated the NA worksheet is where an aide would look for directions on oral cares for residents. On 12/30/14 at 12:30 p.m., the director of nursing (DON) stated individualized oral care directions were listed on the care plan which is found in the electronic record and accessible to all NA's. Upon further interview on 12/30/14 at 2:30 p.m., the DON indicated oral hygiene should be offered at least during morning and evening cares. She further stated oral care is to be individualized offering a tooth brush or toothette; residents are to brush as able, or staff will assist; dentures are to be cleaned and water offered to rinse and mouthwash is to be offered if the resident is able. The DON confirmed using a washcloth to wipe a resident's teeth was not appropriate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	R 12/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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{F 312}	Continued From page 2 12/30/14 review of the NA Worksheet did not indicate if R50 has her own teeth or dentures. The worksheet lacked direction for R50's oral cares.	{F 312}		
{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 (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.	{F 441}		

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{F 441}	Continued From page 3 (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 proper hand hygiene was maintained during personal cares for 1 of 3 residents (R50) reviewed for personal cares. Findings include: R50's diagnoses from the Care Plan edited 9/10/14, included Dementia w/Lewy bodies, aphasia (loss of ability to understand/express speech) related to a cerebral vascular accident (CVA), and Parkinson's Disease. The quarterly Minimum Data Set (MDS) dated 11/29/14, indicated R50 required extensive assistance with dressing, toileting and personal hygiene. On 12/30/14 at 8:19 a.m., nursing assistant (NA)-A donned a pair of gloves from her uniform pocket. NA-A moved the fall mat and wheelchair, went to the closet for clothes, and laid the clothes and clean incontinence product on a chair along with a washcloth and a towel. NA-A initiated cares for R50. NA-A used a walkie-talkie to ask for transfer assistance. NA-A removed R50's soiled incontinence product and placed it in the garbage can. With the same gloved hands, NA-A went to the sink and returned with a wash cloth, towel and	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	R 12/31/2014

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{F 441}	Continued From page 4	{F 441}		

pink basin filled with water. NA-A washed and dried R50's front perineal area.

NA-F entered the room to assist with R50. NA-F donned gloves. NA-A and NA-F rolled R50 to the side and NA-A washed R50's posterior perineal area. The NA's then put a new incontinence product on R50 and assisted her to sit on the edge of the bed. With the soiled gloves on, NA-A pulled the EZ stand (a mechanical lift used to assist with transfers) to the bedside by the handles, buckled R50 into the EZ stand and transferred R50 to the wheelchair. NA-F removed the gloves and exited the room pushing the EZ stand by the handles. NA-F did not wash or sanitize hands after removing the gloves and prior to exiting the room.

NA-A took the pink basin and washcloth to the bathroom and dumped the water into the sink. Without cleaning or sanitizing, NA-A refilled the same pink basin that was used to wash the front and posterior perineal areas with R50. NA-A brought the basin filled with water to R50 and assisted her with washing her face. NA-A washed R50's torso and under arms and returned the basin and washcloth to the bathroom. NA-A put lotion on R50's back, put on her sweatshirt and combed her hair. NA-A picked up the dirty linens from the bedside table. NA-A then removed the soiled gloves, put them in the garbage can and knotted the plastic garbage can liner, dropping it on the floor. NA-A picked up R50's glasses, put them on her face; picked up the bag of garbage and soiled linen and wheeled R50 to the hallway. When asked if there was anything else to do for R50's morning cares, the NA replied, "No." NA-A continued down the hall to the soiled linen room, and using the door handle to enter,

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{F 441}	Continued From page 5 disposed of the linen and garbage. Upon her return to the hallway outside R50's room, NA-A stated she should probably sanitize her hands. For the first time since initiating the observation, NA-A sanitized her hands. On 12/30/14 at 9:49 a.m., NA-A verified she put on a pair of gloves when entering R50's room and did not wash or sanitize hands with cares or upon leaving room. NA-A agreed she washed R50's private areas and later washed R50's face wearing the same gloves. The facility's standard precautions policy dated 6/2002 specified: · Change gloves between residents and as necessary (i.e. torn or contaminated.) DO NOT use contaminated gloves on clean areas. Always work clean to dirty. · Linen is to be handled, transported and processes in a manner that prevents exposure and contamination of clothing and avoid transfer of microorganisms to other residents and the environment. The policy further specified soiled linen should be handled with gloves.	{F 441}		

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245360	A. Building B. Wing	12/31/2014

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **12/15/2014**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **12/15/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/15/2014**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/15/2014**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **12/15/2014**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **12/15/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/15/2014**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **12/15/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **12/15/2014**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **12/15/2014**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **12/15/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	1/12/2015	29433	12/31/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/6/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 7SEX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00314

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245360**

2.STATE VENDOR OR MEDICAID NO.
(L2) **770057500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY OF NEW LONDON**
(L4) **100 GLEN OAKS DRIVE**
(L5) **NEW LONDON, MN** (L6) **56273**

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) **02/01/2011**

6. DATE OF SURVEY **11/06/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **58** (L18)

13.Total Certified Beds **58** (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
	58			
(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 :
Bruce Melchert, HFE NE II 12/18/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 12/23/2014 (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
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/23/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 21, 2014

Mr. James Ingersoll, Administrator
Benedictine Living Community Of New London
100 Glen Oaks Drive
New London, Minnesota 56273

RE: Project Number S5360026

Dear Mr. Ingersoll:

On November 6, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

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 December 16, 2014, 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 December 16, 2014 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 6, 2015 (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 6, 2015 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	11/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a dignified dining experience for 2 of 4 dependent residents (R5 and R50), who were assisted to eat while staff were standing next to them and/or had to wait an extended period of time to be served the meal and receive assistance. In addition, facility staff failed to answer a call light timely for 1 of 5 residents (R6) observed during morning cares, who required assistance with toileting. Findings include:	F 241	Staff education related to timely meal service, need to be seated while feeding a resident, re: not cancelling a call light until the staff is able to assist that resident with their needs, and protocol for use of colored call lights has been provided, and has been added to the CNA orientation checklist for consistent teaching for each new hire. Call light wait times and timely meal service added to Resident Council agendas monthly.	12/15/14

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

Electronically Signed | 12/05/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 1 R5's annual Minimum Data Set (MDS) dated 9/18/14, indicated moderately impaired cognition, and identified R5 required extensive assistance to eat. During observation on 11/4/14, at 9:04 a.m. R5 was seated in his wheel chair at a table in the main dining room during the breakfast meal. Nursing assistant (NA)-H approached R5 and fed him a spoon of oatmeal while standing next to his chair. NA-H then asked R16 if he wanted any more cereal, R5 shook his head, and NA-H left to assist another resident. During observation on 11/5/14, at 8:00 a.m. R5 was again seated in his wheel chair at the table for breakfast. NA-H approached R5, poured a glass of juice and set the glass in front of him, then left R16's table and began attending other residents. From 8:00 a.m. until 8:49 a.m. R5 remained at the table, unattended, and intermittently appeared to be sleeping. At 8:30 a.m., R26 joined R5 at the table to his left. NA-H took R26's breakfast menu request. At 8:33 a.m. NA-H served R26's breakfast. R5 was not offered food, and remained unassisted during this time. At 8:49 a.m., 49 minutes after R5 was seated in the dining room, NA-H delivered R5's breakfast meal, which included a fried egg, toast, a bowl of oatmeal, and a container of yogurt. NA-H set the plate in front of R5, placed a clothing protector on his chest, then left him at the table, and assisted	F 241	Resident Council responses related to call lights and timely meal service from Resident Council will be audited monthly with reports to the Quality Council. Dining Room will be observed utilizing the Dignity portion of the Dining Observation provided by CMS (Form CMS-20053) weekly x 4 weeks, then biweekly x 1 month, then quarterly throughout the following year, with results reported to the Quality Council by Social Service Director or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	11/06/2014

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BENEDICTINE LIVING COMMUNITY OF NEW LONDON	**100 GLEN OAKS DRIVE NEW LONDON, MN 56273**

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F 241	Continued From page 2 others in the dining room. R5 picked up his juice, and drank half a glass. NA-A continued to assist other residents. R5 did not attempt to feed himself again. At 9:02 a.m. NA-H sat down and began assisting R5. During an interview on 11/5/14, at 11:24 a.m. LPN-B stated, "It is frustrating that R5 doesn't get timely help with meals." LPN-B stated R5 was diabetic and required assistance to eat. LPN-B stated she was aware R5 did not receive timely assistance at the breakfast meal, "I don't know how else that could be done, one person can only do so much." When interviewed on 11/5/14, at 11:50 a.m. NA-H stated she often fed R5 while standing next to him. "I know you shouldn't do it, but I go from one to another, and get more than one resident fed at the same time." NA-H stated she felt the residents were getting, "Short changed," as there was not enough staff available to assist with breakfast. When interviewed on 11/6/14, at 12:15 p.m. the assistant director of nursing (ADON) stated, "Typically, staff should be seated while feeding the resident," and the nurse aide should begin assisting residents when they are served. When interviewed on 11/6/14, at 2:05 p.m. the director of nursing (DON) stated residents should not have to wait extended periods to receive their meal, or to receive assistance.	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	11/06/2014

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F 241	Continued From page 3 R50's MDS dated 8/29/14, indicated R50 had dementia with long and short term memory problems, and required extensive assistance for eating. During observation of the breakfast meal, on 11/6/14, at 9:11 a.m. R50 was seated at a table in the main dining room. NA-I was standing up at the table, to R50's right side, feeding her. When interviewed on 11/6/14, at 9:13 a.m. NA-I stated they should be seated when helping residents eat, so they can visit and talk with them. Further, NA-I stated standing up while feeding was just, "...bad habit I suppose." During interview on 11/6/14, at 11:52 a.m. LPN-C stated R50 was dependant on staff for eating, and staff should not be standing up while helping her, "It's a dignity issue, you want to be at their level." When interviewed on 11/6/14, at 12:10 p.m. registered nurse (RN)-A stated staff frequently are seen standing up to feed residents in the dining room. Further, RN-A stated staff should be seated at eye level with residents as they assist them with eating. During interview on 11/6/14, at 12:30 p.m. the DON she has occasionally observed staff standing next to residents to feed them, depending on how many residents need help at	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 4 the same time. Further, the DON stated it was a dignity concern and staff should not being standing up while helping residents eat, "We definitely try not to do that." R6's MDS dated 10/21/14, indicated she had intact cognition, was frequently incontinent of urine, and required extensive assistance from two staff to complete bed mobility, transfers, and toileting. During continuous observation, beginning on 11/5/14, at 8:07 a.m. R6 was found lying in bed with her eyes open and her bedroom lights on. The green indicator above her door, indicating staff were in the room, was illuminated, however no staff were present. NA-E was observed, at 8:28 a.m., to walk up to the door of the room and looked inside, however kept walking down the hallway. R6 remained in bed with the lights on and not receiving assistance from staff until 8:37 a.m., when nursing assistant (NA)-A and NA-B entered the room and provided assistance. R6 had been incontinent of urine, and her draw sheet on the bed was visibly soiled with urine. During interview on 11/5/14, at 8:22 a.m. R6 stated there has been occurrences before of staff turning on her bedroom lights and not returning to help her for a long period of time. Having to wait for help with the lights on was upsetting to her, and, "Not really appropriate." Further, R6 stated she has waited up to two hours in the past for help.	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 5	F 241		

During interview on 11/5/14, at 8:46 a.m. NA-A stated she had turned R6's bedroom lights on this morning as she thought the bath aide would be coming to help her. Further, NA-A stated similar situations (residents waiting long periods of time to get assistance) had been occurring lately due to short staffing at the facility.

A Bed Activity report, dated 11/5/14, indicated R6 turned her call light on at 7:53 a.m., and staff responded at approximately 8:00 a.m.. Further, the report indicated a "staff time" (time spent with the resident after answering the call light and illuminating the green signal above the door) of 37 minutes and 32 seconds. R6 had been laying in bed with her bedroom lights on for over 37 minutes before getting help from staff.

When interviewed on 11/5/14, at 1:03 p.m. RN-A stated occurrences of residents having to wait long periods before getting help have happened before. Call lights are to be answered within 5 minutes, and R6 laying in bed for that amount of time (over 37 minutes) was unreasonable, and a dignity concern for her as she was dependant on staff for help.

During interview on 11/6/14, at 12:32 p.m. the DON stated call lights should be answered within 10 minutes, however R6 should not have been left in bed with her lights on.

A Quality of Life - Dignity policy, dated 10/2009,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(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 241	Continued From page 6 indicated each resident should be cared for in a manner that promotes and enhances the quality of life, dignity, respect, and individuality of the resident. Further, the policy indicated, "Residents shall be treated with dignity and respect at all times."	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R16) reviewed for accommodation of needs, was able to access his bathroom sink, to effectively be able to perform independent hygiene activities. Findings include: R16's annual Minimum Data Set (MDS), dated 7/28/14, indicated intact cognition, and that he had bilateral, upper and lower extremity impairment. During observation on 11/3/14, at 6:18 p.m. R16 was seated in an electric wheel chair, which he	F 246	All residents that are physically able to move about independently and are cognitively able to utilize modifications have been interviewed to identify if modifications need to occur. No further modifications have been requested. Format for care conferences has been modified to include questions re: ability to access areas in room to identify opportunities for accommodations to prevent recurrence. Care conference documentation will be audited by Social Service Director monthly x 3 months, then quarterly throughout the following year with results reported to the Quality Council.	12/15/14

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	245360	A. BUILDING _____ B. WING _____	11/06/2014

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F 246	Continued From page 7	F 246		

maneuvered into his bathroom, in front of the sink and mirror. R16 controlled the wheel chair via a joy-stick on right arm rest, which was elevated and rested upon the sink countertop. The left arm rest of the wheel chair bumped against the faceboard of the sink countertop, as did R16's knees. The wheel chair was parked as close to the sink as possible, yet R16's abdomen remained approximately six inches from the countertop.

In an interview on 11/3/14, at 6:22 p.m. R16 stated he had spoken with facility staff, "...last winter" about not being able to get close enough to the sink. R16 stated that the maintenance person he talked with no longer worked at the facility, and, "The whole thing just fell by the wayside." R16 stated the faceboard from the countertop prevented, "my knees and my wheelchair from getting any closer." He could get closer, "If that board was cut off." R16 stated this was important to him, because, "I brush my teeth after each meal." He routinely kept a clothing protector on when he left the dining room, and upon returning to his room, kept it on while he brushed his teeth, "so I don't get spit all over my shirt." R16 stated he also wanted a shelf put up in the bathroom, "...to get the clutter off the sink counter." R16 stated he had spoken with someone at the facility about two weeks ago, but that, too, seemed to, "fall on deaf ears." R16 didn't want to complain for "fear that I might lose the room."

During an interview on 11/5/14, at 12:35 p.m. maintenance worker (MW)-B stated the edge of the sink, "could somehow be changed so [R16]

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F 246	Continued From page 8 could park closer to the sink." MW-B stated he was confident, "we could do it, or have our carpenter make the necessary cut." In an interview at on 11/5/14, at 12:36 p.m. the facility administrator stated he was unaware of R16's concerns regarding the sink, and possibly putting up a shelf. "This happened prior to my arrival." The administrator then stated, "We could easily make this accommodation," and added, "if this makes it better for the resident, then let's do it." A facility policy "Accommodation of Needs," dated 12/2002, indicated the facility's physical environment "should be directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity, and well being to the extent possible in accordance with he resident's own preferences and care plans."	F 246		
F 282 SS=E	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 implement the care planned interventions for restorative nursing, oral care, incontinence care and/or fall prevention, for	F 282	Restorative program has been reorganized with additional staff designated to provide restorative, with two CNAs sharing the duties on AM shift and,	12/15/14

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F 282	Continued From page 9 7 of 32 residents (R17, R50, R5, R32, R65, R42 and R37) reviewed for care plan implementation. Findings include: R17's significant change Minimum Data Set (MDS) dated 9/6/14, included diagnoses of a stroke and dementia, had severe cognitive impairment, did not ambulate and did not receive restorative nursing. R17's care plan dated 9/15/14, indicated he was to walk with CGA of one, and handrail with wheelchair (WC) pulled behind daily. R17's Restorative Flow sheet for May 2014 to October 31st 2014 included R17 was to ambulate 50 feet daily, and was documented as follows: May 2014: 20 days was marked as "pulled." June 2014: 6 days marked as, "pulled." 1 blank, 3 marked with a zero, and 3 circled with no explanation. July 2014: 20 days marked as "pulled." 1 day blank, and 2 days marked as refused. August 2014- completed twice, 9 refusals and 17 blanks (no initial indicating it was completed) September 2014- completed 6 times from 9/1/14 to 9/22/14 pulled (restorative aide was pulled to floor did not complete program) October 2014- completed 5 times, 2 refusals, 1 illness and "pulled" 14 times. During interview 11/6/14, at 12:59 p.m.	F 282	by 12/22/14, one designated on PM shift as well. Nursing staff have been educated about the importance of providing assistance with oral cares with AM and PM cares. Staff education re: tab alarms being secured to a stationary object to function properly. Added to CNA orientation checklist for consistent training for each new hire. Staff education for Nursing and Housekeeping staff re: the need to replace Dicem if removed from WC or under mattress. Director of Nursing or designee will perform audits for restorative completion and documentation, oral care completion for 10% of facility population, and safety devices will be weekly x 4 weeks, then biweekly x 1 month, then quarterly throughout the following year, with results reported to the Quality Council. Documentation of routine 30 minute checks has been added to the Repositioning and Toileting sheet for the one resident with 30 minute checks. Education for Nursing staff re: importance of ensuring this resident□s safety has been ongoing and will be completed by 12/15/14. Monitoring will be 3x weekly x 2 weeks, then weekly x 2 weeks, biweekly x 1 month, monthly x 4 months, then quarterly throughout the following year with results reported to the Quality Council	

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F 282	Continued From page 10 restorative therapy aide (RTA)-A stated she is pulled to the floor to work as a nursing assistant (NA) because the facility is short staffed. This is what, "pulled," means on the flow sheets. The RTA-A stated this had been happening for several months and the restorative nursing programs are not completed when she is pulled to the floor to work. The RTA-A further stated R17 has not had a decline in his ambulation. During interview 11/6/14, at 1:12 p.m. director of nursing (DON) stated the restorative nursing programs should be completed and if the RTA is pulled to the floor each individual nursing assistant is responsible to complete the restorative nursing on there residents. During interview 11/6/14, at 1:20 p.m. NA-C stated when the RTA is pulled to the floor she is unable to complete the restorative nursing because she has too much work to do. During interview 11/6/14, at 1:25 p.m. NA-D stated she does not have the time when she is working on the floor to also complete the restorative nursing if the RTA is pulled to the floor. R50's quarterly MDS dated 8/29/14, included diagnoses of a stroke and Parkinson's disease. The MDS indicated R50 had severe cognitive impairment, required assistance with activities of daily living (ADL's), had no impairment with upper or lower extremity range of motion (ROM), and did not receive a restorative nursing program.	F 282	by Director of Nursing or designee. Teaching for all of the above is ongoing and will be completed by 12/15/14.	

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F 282	Continued From page 11 R50's care plan dated 9/10/14, indicated R50 was at risk for a decline and instructed a restorative nursing program for ROM to bilateral upper extremities (UE) and lower extremities (LE) in a pain free motion daily per restorative therapy aide (RTA). Restorative Nursing Flow sheet reviewed from August 2014 to October 2014 indicated AROM (active range of motion) or PROM to bilateral and lower extremities once a day. The Restorative nursing flow sheet indicated the following: August 2014- there were 7 blank documentation days, and 8 marked as, "pulled." September 2014- there were 23 days marked as, "pulled." Only 7 days as being completed. October 2014- there were 4 blank documentation days, and 16 marked as, "pulled." During interview 11/6/14, at 12:59 p.m. RTA-A stated she was pulled to the floor due to the facility being short staffed. RTA-A stated R50 had not had a decline in her ROM. R5's quarterly MDS dated 09/18/14, included diagnoses of dementia and a stroke with hemiplegia (paralysis of one side of body) or hemiparesis (weakness on one side), functional limitation of both lower extremity ROM, but did not receive a restorative nursing program.	F 282		

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R5's care plan dated 09/30/14, indicated he had diagnosis of left ankle fracture related to fall 8/13, and CVA (stroke). Staff were directed to perform ankle and foot ROM per PT (physical therapy) recommendation daily as he can tolerate.

R5's Restorative Flowsheet dated 11/1/14, directed the restorative nursing program for ankle and foot PROM dorsiflexion (toes downward) 15 reps each foot then repeat. Heel cord stretches (hold toes upward as he tolerates) x 30 seconds, 3 reps to each foot/ankle then repeat once a day.

R5's Restorative Flowsheet indicated the following:
August 2014- the daily PROM was documented as being completed 15 times, marked as "pulled," 9 times, and left blank 7 times.
September 2014- the daily PROM was documented as being completed 6 times, "pulled" 23 times, and left blank once.
October 2014- the daily PROM was documented as being completed 8 times, "pulled 19 times, and left blank 4 times.

During interview 11/6/14, at 1:05 p.m. RTA-A stated she was pulled to the floor due to the facility being short staffed and had not been able to routinely complete the restorative program for R5. RTA-A stated R5 had not had a decline in her ROM.

During interview 11/6/14, at 1:12 p.m. director of

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F 282	Continued From page 13 nursing (DON) stated the restorative nursing programs should be completed and if the RTA is pulled to the floor each individual nursing assistant is responsible to complete the restorative nursing on there residents. During interview 11/6/14, at 1:20 p.m. with NA-C who stated when the RTA is pulled to the floor she is unable to complete the restorative nursing because she has too much work to do. During interview 11/6/14, at 1:25 p.m. with NA-D stated she does not have the time when she is working on the floor to also complete the restorative nursing if the RTA is pulled to the floor. The facility Rehabilitative Nursing Care policy revised 2007, indicated "Nursing personnel are trained in rehabilitative nursing care. Our facility has an active program of rehabilitative nursing which is developed and coordinated through the resident's care plan." R32's quarterly MDS dated 8/11/14, included diagnoses of a stroke with hemiplegia (one sided paralysis) or hemiparesis (one sided weakness) and dementia, was moderately cognitively impaired, had unsteady balance, and had two falls since the previous assessment. R32's care plan dated 8/20/14, indicated she was at risk for falls, had a wrist fracture from a fall in February 2014, and was more dependent on	F 282		

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F 282	Continued From page 14 staff for activities of daily living (ADL's). Staff were instructed to ensure bed was in low position, dicem (non skid mat) under the perimeter defined mattress (a mattress with a raised edge), dicem to wheelchair, and "tabs" (a personal alarm system which has a string that attaches to the residents clothing at one end, and attached to a magnet on a box, when pulled off the magnet, an alarm sounds) alarm on at all times. R32's Fall Scene Investigation Reports included R32 had fallen on 7/26/14 while alarm string was too long. R32's Fall Schen Investigation Report dated 9/9/14, included R32 had fallen while her bed was, "not at appropriate height," and alarm was not on resident. During observation 11/04/14, at 7:00 a.m. R32 was observed lying in bed with the head of the bed (HOB) elevated 30 degrees and with Personal Sentry Fall Monitoring System (PSFMS) (same alarm type as the TABs alarm) lying on the bed unsecured lying on top of the pillow. There was no dicem under the perimeter mattress or on R32's wheelchair which were both identified on the care plan During interview 11/5/14, at 8:09 a.m. resident therapy assistant (RTA)-A verified there was no dicem in R32's wheelchair or under the mattress, and should have been. R65's significant change MDS dated 10/08/14,	F 282		

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F 282	Continued From page 15 included a diagnosis of dementia, severe cognitive impairment, required extensive assistance for transfers, and had falls since the last assessment. R65's care plan dated 10/14/14, indicated he had impaired mobility r/t weakness and worsening dementia. The care plan further indicated he had interventions in place to prevent falls and had one fall out of bed since admission with minor injuries. The care plan indicated to have bed in low position, mat by bedside. R65's nursing assistant care sheet dated 11/5/14, included, tab alarm at all times, mat next to bed, and bed in low position at all times. R65's Resident Incident Report dated 7/14/14, included R65 had been found on the floor, the personal alarm was not on the resident. During observation 11/05/14, at 7:00 a.m. R65 was observed to be lying in bed with tabs alarm laying on his bed, which was not secured to anything. During interview 11/5/14, at 10:15 a.m. the DON stated R65's tabs alarm should have been fastened to his bed. R65's significant change Minimum Data Set (MDS) dated 10/8/14, included a diagnosis of dementia, and required extensive assistance with personal hygiene.	F 282		

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F 282	Continued From page 16 R65's care plan dated 10/14/14, included R65 had upper and lower denture, with implant in lower jaw to attach denture to, and directed staff to assist with oral cares twice a day. During observation 11/5/14, at 7:00 a.m. R65 was in bed fully dressed with the dentures in his mouth. Nursing assistant (NA)-B stated the night shift had dressed and groomed R65 for the day. NA-B, "assumed" the night shift had performed oral hygiene for R65. During interview on 11/5/14, at 7:57 a.m. NA-E stated she had started her shift at 4:00 a.m. and assisted R65 with morning cares, at which time she had checked R65's denture cup, which was empty. NA-A stated, "this means his teeth were not cleaned last night." NA-E had not performed oral hygiene for R65 during morning cares either. During interview 11/5/14, at 11:53 a.m. the director of nursing (DON) stated R65's teeth should have been cleaned as directed by the care are plan. R42's last quarterly Minimum Data Set (MDS), dated 8/28/14, indicated that R42 had diagnoses which included Alzheimer's disease, depression and contractures of the upper extremities (including the shoulders) and was severely cognitively impaired. The MDS also indicated R42 received extensive of two staff assistance with most activities of daily living (ADLs), and was receiving restorative nursing for passive range of motion (PROM).	F 282		

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R42's Care Plan, last reviewed for care conference on 10/29/14, indicated R42 was to receive restorative nursing, with "PROM daily per therapy recommendations."

During observations on 11/06/14, from 8:15 a.m. through 10:30 a.m., there were no indications that R42 had received PROM from facility staff as directed by the care plan.

During an interview on 11/06/14 at 12:59 p.m., nursing assistant (NA)-B and restorative assistant (RA)-A stated that PROM had not been completed this day, while NA-A had been pulled from the restorative nursing role, to a cover direct care position. RA-A and NA-B both stated they were not able to complete the PROM for R42 as identified by the care plan, because theory were too busy with other residents, so R42's PROM was not being completed.

R37's quarterly MDS dated 8/22/14, included severe cognitive impairment with a neurological disease which causes uncontrolled movements and required extensive to total staff assistance for ADL's.

R37's vulnerability care plan dated 8/25/14, identified R37 was to have, "safety checks every 30 minutes."

During continuous observation on 11/5/14 from 7:06 a.m. until 8:54 a.m., (one hour and 48 minutes), there were no facility staff that entered R37's room to check on her. During this time,

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F 282	Continued From page 18 R37 was behind the wall in her room, and was not visible from the hallway. At 8:54 a.m., NA-C and NA-E entered R37's room and announced, "We are here to start your morning cares." During interview on 11/05/14, at 9:14 a.m. NA-C stated R37 was to be checked on every 30 minutes, but they were short staffed and this had not occurred this morning. NA-C showed a nurse aide work sheet, which showed a hand-written note to check on R37 every 30 minutes. During interview on 11/6/14, at 8:45 a.m. registered nurse (RN)-A stated R37 was supposed to be checked every 30 minutes. RN-A stated R37 was at risk for, "Bruises and injuries due to her involuntary movements." RN-A stated the nursing assistants, "...are aware of this it is on their assignment sheets," and should be doing every 30 minutes for R37's safety.	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, 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 provide wheelchair	F 309	Care plan was revised to include footrests when being pushed in WC. All	12/15/14

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F 309	Continued From page 19 foot pedals, to prevent feet from dragging on the floor, for 1 of 3 residents (R75) reviewed for wheel chair positioning. Findings include: R75's quarterly Minimum Data Set (MDS), dated 10/22/14, indicated R75 had severe cognitive impairment, was non-ambulatory, and required extensive assistance with transfers and locomotion and utilized a wheelchair. R75's care plan, dated 10/31/14, indicated R75 required assistance for all mobility, and listed an intervention of, "No foot pedals unless being pushed a long distance or for appointments." During observation on 11/4/14, at 9:16 a.m. R75 was seated in his wheelchair in the doorway of his room wearing a thick, rubber soled boots. R75 was pushed to the dining room by nursing assistant (NA)-E with his feet dragging on the ground, folded under the wheelchair, making an audible screeching noise. When observed on 11/5/14, at 9:19 a.m. R75 was seated in his wheelchair, in his room, wearing the same rubber soled boots. NA-F began pushing R75 out of his room in his wheelchair with his feet dragging on the floor. NA-F stopped and asked R75 to hold his feet up, however R75 stated he was unable to do so. NA-F continued pushing R75 to the dining room; his right foot folded under the wheelchair and making an audible screeching	F 309	residents that routinely use WCs have been evaluated for appropriateness of and safety with footrests. Staff education for current re: potential for feet dragging on floor when pushed by staff. Added to NA/R orientation checklist for consistent training with all new NA/R hires. All newly admitted residents using wheelchairs will be evaluated for the need for footrests when moving about in the WC and/or being transported by staff. Monitoring of seated positioning will be completed monthly for 20% of the facility population with results reported to the Quality Council by Director of Nursing or designee. Teaching is ongoing and will be completed by 12/15/14.	

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F 309	Continued From page 20 noise. When interviewed on 11/5/14, at 9:29 a.m. NA-F stated other staff push R75 in his wheel chair without wheelchair pedals in place as well. R75 is rarely able to keep his feet up, and she was unsure why R75 did not have foot pedals for his wheelchair. Further, NA-F stated R75 should have foot pedals in place when being assisted with locomotion in his wheelchair to prevent his feet from dragging on the floor. During interview on 11/5/14, at 11:19 a.m. registered nurse (RN)-B stated R75's wheelchair pedals were removed after he had sustained a fall, so he could self propel easier. RN-B stated a long distance was defined as an outside appointment, or going to the therapy gym in the building. Further, RN-B stated if R75 was not able to hold his feet up, he should have been using wheelchair pedals while being pushed in his wheelchair, "I will have to look into that." When interviewed on 11/5/14, at 11:24 a.m. the certified occupational therapy assistant (COTA)-A stated R75 had been last seen by therapy (OT) in July 2014, and no recommendations had been made regarding R75's wheelchair positioning or use of foot pedals. No request for wheelchair positioning or foot pedal use had been requested by nursing for R75 since he had been seen by OT in July 2014. Further, COTA-A stated stated R75 should have foot pedals in place if he is unable to keep his feet up during wheelchair locomotion.	F 309		

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F 309	Continued From page 21 R75's Therapist Progress & Discharge Summary, dated 7/21/14, did not indicate any concerns for positioning, or identify a reason for the lack of wheelchair pedals for R75. During interview on 11/5/14, at 11:50 a.m. the director of nursing (DON) stated R75 should not be pushed in his wheelchair with his feet folded underneath the chair, and it was, "...definitely a concern." A facility policy entitled, Position A Resident In Chair/Wheelchair, dated 12/2002, indicated a standard of, "...nursing care directed toward preservation of optimal levels of function and independence and prevention of deterioration and complications of disability." Further, the policy indicated a procedure of maintaining residents' proper body alignment, including ensuring residents, "..feet are flat on the floor or footrests of the wheelchair."	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide and consistently implement restorative ambulation services to improve and/or maintain the resident's ambulation ability for 1 of 3 residents (R17)	F 311	Resident # 17 has since passed away. No current residents with a specialized walking program that requires specific training of staff to administer. All walking plans are implemented by CNAs. Walking	12/15/14

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F 311	Continued From page 22 reviewed for ambulation. Findings include: R17's significant change Minimum Data Set (MDS) dated 9/6/14, included diagnoses of a stroke and dementia, had severe cognitive impairment, did not ambulate and did not receive a restorative nursing program. R17's Physical Therapy Plan of Care Evaluation dated 6/30/14, referred R17 to a restorative nursing program due to increased lower extremity weakness, and instructed staff to ambulate him with contact guard assistance, hand rail and pull wheel chair behind daily, with a goal of 50 feet each day. R17's care plan dated 9/15/14, included he had impaired mobility requiring assistance with ambulation. The care plan instructed to staff to ambulate with him using contact guard assist of one, the hand rail, and pull the wheel chair behind him daily. During observation 11/05/14, at 7:00 a.m. R17 was lying in bed with his clothes on monitor alarm string attached to him and monitor lying on bed unsecured. R17's Restorative Flow sheet for May 2014 to October 31st 2014 included R17 was to ambulate 50 feet daily, and was documented as follows:	F 311	programs that require specific training of staff will be administered by the CNAs and appropriate staff will be trained to assist those residents. Monitoring of completion and documentation of walking programs will be weekly x 4 weeks, then biweekly x 1 month, then quarterly throughout the following year, with results reported to the Quality Council, by Director of Nursing or designee. Teaching is ongoing and will be completed by 12/15/14.	

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F 311	Continued From page 23 May 2014: 20 days was marked as "pulled." June 2014: 6 days marked as, "pulled." 1 blank, 3 marked with a zero, and 3 circled with no explanation. July 2014: 20 days marked as "pulled." 1 day blank, and 2 days marked as refused. August 2014- completed twice, 9 refusals and 17 blanks (no initial indicating it was completed) September 2014- marked as, "pulled," 23 times. October 2014- completed 5 times, 2 refusals, 1 illness and "pulled" 14 times. R17's Restorative Nursing Progress note dated 6/4/14 included, "Restorative Nursing offered 7 days/week...Participation...14 days last month...he was ill 3 days and weak 1 day." The note went on to indicate R17 had ambulated 20-80 feet every day. The note failed to address the 20 days in May 2014, that was marked as, "pulled." R17's Restorative Nursing Progress note dated 7/14/14, included, "Restorative Nursing: offered 7 days/week...Participation...7 days last month. He was ill or tired 7 days and unable 1 day due to weakness. The note went on to indicate R17 had ambulated 10-80 feet every day. The note failed to address why 6 days in June had been marked as, "pulled." R17's Restorative Nursing Progress note dated 9/2/14, included the ambulation program had been offered 7 days/week, and that he had refused 11 days and worked with physical therapy 4 days. The note also included, "he has had	F 311		

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F 311	Continued From page 24 trouble w/ (with) walking and MD (medical doctor) feels this is a progress of his MS (muscular sclerosis, a muscle wasting disease). During interview 11/6/14, at 12:59 p.m. restorative therapy aide (RTA)-A stated she is pulled to the floor to work as a nursing assistant (NA) because the facility is short staffed. This is what, "pulled," means on the flow sheets. The RTA-A stated this had been happening for several months and the restorative nursing programs are not completed when she is pulled to the floor to work. The RTA-A further stated R17 has not had a decline in his ambulation. During interview 11/6/14, at 1:12 p.m. director of nursing (DON) stated the restorative nursing programs should be completed and if the RTA is pulled to the floor each individual nursing assistant is responsible to complete the restorative nursing on there residents. During interview 11/6/14, at 1:20 p.m. NA-C stated when the RTA is pulled to the floor she is unable to complete the restorative nursing because she has too much work to do. During interview 11/6/14, at 1:25 p.m. NA-D stated she does not have the time when she is working on the floor to also complete the restorative nursing if the RTA is pulled to the floor. The facility Rehabilitative Nursing Care policy revised 2007, indicated "Nursing personnel are	F 311		

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F 311	Continued From page 25 trained in rehabilitative nursing care. Our facility has an active program of rehabilitative nursing which is developed and coordinated throughout the resident's care plan."	F 311		
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 oral hygiene for 1 of 3 residents (R65) reviewed for oral care. Findings include: R65's significant change Minimum Data Set (MDS) dated 10/8/14, included a diagnosis of dementia, and R65 required extensive assistance with personal hygiene. R65's care plan dated 10/14/14, included R65 had upper and lower denture, with implant in lower jaw to attach denture to, and directed staff to assist with oral cares twice a day. During interview 11/4/14, at 5:23 p.m. R65's family member (FM)-A stated R65 does not	F 312	Nursing staff have been educated about the importance of providing assistance with oral cares with AM and PM cares. Monitoring of oral care completion for 10% of facility population will be weekly x 4 weeks, then biweekly x 1 month, then quarterly throughout the following year, with results reported to the Quality Council, by Director of Nursing or designee. Teaching is ongoing and will be completed by 12/15/14.	12/15/14

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F 312	Continued From page 26 receive oral hygiene routinely and that she had spoken with various staff members about this concern, including the assistant director of nursing (ADON). FM-A's concern had not been addressed, "I have just given up." During observation 11/5/14, at 7:00 a.m. R65 was observed in bed fully dressed with the dentures in his mouth. Nursing assistant (NA)-B stated the night shift had dressed and groomed R65 for the day. NA-B, "assumed" the night shift had performed oral hygiene for R65. During interview on 11/5/14, at 7:57 a.m. NA-E stated she had started her shift at 4:00 a.m. and assisted R65 with morning cares, at which time she had checked R65's denture cup, which was empty. NA-A stated, "this means his teeth were not cleaned last night." NA-E had not performed oral hygiene for R65 during morning cares either. During interview 11/5/14, at 11:53 a.m. the director of nursing (DON) stated R65's teeth should have been cleaned. The facility Oral Hygiene policy dated 12/2002, included, "Nursing staff will provide assistance with oral hygiene to each resident every morning, night and as needed, unless otherwise specified in residents plan of care."	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 318		12/15/14

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F 318	Continued From page 27 with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide nursing rehabilitative services as ordered for 3 of 5 resident's (R50, R5 and R42) reviewed for rehabilitative services to maintain or increase range of motion (ROM). Findings include: R50's quarterly MDS dated 8/29/14, included diagnoses of a stroke and Parkinson's disease. The MDS indicated R50 had severe cognitive impairment, required assistance with activities of daily living (ADL's), had no impairment with upper or lower extremity range of motion (ROM), and did not receive a restorative nursing program. R50's care plan dated 9/10/14, indicated R50 was at risk for a decline and instructed a restorative nursing program for ROM to bilateral upper extremities (UE) and lower extremities (LE) in a pain free motion daily per restorative therapy aide (RTA). R50's Physical Therapy Progress & Discharge Summary dated 5/21/13, indicated she had full ROM against gravity and moderate resistance and the discharge plan was to remain in the	F 318	All residents with restorative programs have been identified. Restorative program has been reorganized with additional staff designated to provide restorative, with two CNAs sharing the duties on AM shift and, by 12/22/14, one designated on PM shift as well. Monitoring for completion and documentation will be weekly x 4 weeks, then biweekly x 1 month, then quarterly throughout the following year, with results reported to the Quality Council, by Director of Nursing or designee. Teaching is ongoing and will be completed by 12/15/14.	

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F 318	Continued From page 28	F 318		

facility with restorative nursing program. R50's Physical Therapy Plan of Care dated 8/27/13, indicated physician requesting PT to set up a ROM program for restorative nursing for contractures prevention. The goal indicated "the patient will tolerate up to 3 sets of 10 reps of passive ROM (PROM) to UE and LE for contractures prevention without c/o [complaints of] pain."

Restorative Nursing Flow sheet reviewed from August 2014 to October 2014 indicated AROM or PROM to bilateral lower extremities once a day.

The Restorative nursing flow sheet indicated the following:
August 2014- there were 7 blank documentation days, and 8 marked as, "pulled."
September 2014- there were 23 days marked as, "pulled." Only 7 days as being completed.
October 2014- there were 4 blank documentation days, and 16 marked as, "pulled."

During interview 11/6/14, at 12:59 p.m., restorative therapy aide (RTA)-A stated she was pulled to the floor due to the facility being short staffed and was unable to routinely perform the restorative programs for residents. RTA-A stated R50 had not had a decline in her ROM.

R50's quarterly Minimum Data Set (MDS) dated 8/29/14, included diagnoses of cerebral vascular accident (CVA) and Parkinson's. The MDS indicated she was severely cognitively impaired, and needed extensive assist of two with transfers and dressing and had no impairment with upper and lower extremity ROM. The MDS further indicated she did not receive a restorative nursing

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F 318	Continued From page 29 program. R50's care plan dated 9/10/14, indicated she received ROM to bilateral upper extremity (UE) and lower extremity (LE) in a pain free motion daily per restorative therapy aide (RTA). R50's Physical Therapy Progress & Discharge Summary dated 5/21/13, indicated she had full ROM against gravity and moderate resistance and the discharge plan was to remain in the facility with restorative nursing program. R50's Physical Therapy Plan of Care dated 8/27/13, indicated physician requesting PT to set up a ROM program for restorative nursing for contractures prevention. The goal indicated "the patient will tolerate up to 3 sets of 10 reps of passive ROM (PROM) to UE and LE for contractures prevention without c/o pain. Restorative Nursing Flowsheet reviewed from August 2014 to October 2014 indicated AROM or PROM to bilateral and lower extremities once a day. The Restorative nursing flow sheet indicated the following: August 2014- the program was completed 13 out of 31 opportunities. September 2014- program was completed 6 out of 30 opportunities. October 2014- program was completed 6 out of 30 opportunities. During interview 11/6/14 at 12:59 p.m., restorative therapy aide (RTA)-A stated she was pulled to the floor due to the facility being short staffed. RTA-A stated R50 had not had a decline in her ROM.	F 318		

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R5's quarterly MDS dated 09/18/14, indicated he was moderately cognitively impaired and was totally dependent on staff with transfers and bed mobility and had no impairment with his UE ROM and impairment on both sides of his LE ROM.

R5's care plan dated 09/30/14, indicated he had diagnosis of left ankle fracture related to fall 08/2013, and CVA. The care plan also indicated ankle and foot ROM per PT recommendation daily as he can tolerate.

The Care Area Assessment (CAA) dated 9/30/14, indicated "self care deficit r/t (related to) immobility d/t (due to) h/o (history of) distal femur fractures along w/hx of RT and LT hip fracture, CVA w/(R) hemiparesis".

The Restorative Flowsheet dated 11/01/14, indicated ankle and foot PROM dorsiflexion (toes downward) 15 reps each foot then repeat. Heel cord stretches (hold toes upward as he tolerates) x 30 seconds, 3 reps to each foot/ankle then repeat once a day.

R5's Restorative Flowsheet indicated the following:
May 2014-the daily PROM was documented as being completed 17 times, "pulled" 13 times, and left blank 1 time.
June 2014-the daily PROM was documented as being completed 20 times, "pulled" 8 times and 2 days in the hospital.
July 2014-the daily PROM was documented as being completed 10 times, "pulled" 18 times, and

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F 318	Continued From page 31 left blank 3 times. August 2014- the daily PROM was documented as being completed 15 times, marked as "pulled," 9 times, and left blank 7 times. September 2014- the daily PROM was documented as being completed 6 times, "pulled" 23 times, and left blank once. October 2014- the daily PROM was documented as being completed 8 times, "pulled 19 times, and left blank 4 times. R5's June 2014 restorative progress notes dated 7/31/14, included, "Resident participates well with ROM. No pain with ROM noted. No refusing noted. ROM performed 19/30 days this month. Res (resident) did not refuse at all, was in hosp (hospital) 2 days." There was no explanation as to why the restorative aide was "pulled" 8 times and the PROM was not performed. R5's July 2014 restorative progress note dated 8/21/14, included, "Plans: Bilateral ankle and foot PROM, dorsiflexion and plantar flexion of each foot 15 reps (repetitions) each foot, and heel cord stretches x 30 sec (seconds) 3 reps each foot." The note failed to identify R5 was only provided with PROM 10 times out of the 31 days, and the restorative aide was "pulled" 18 times and there was no documentation 3 times. R5's August 2014, restorative progress note dated 9/25/14, included, "Plans: Bilateral ankle and foot PROM, dorsiflexion and plantar flexion of each foot 15 reps each foot, and heel cord stretches x 30 sec, 3 reps each foot." The note failed to identify why the PROM was only performed 15 times out of 31 days, and 9 were marked as "pulled," and 7 days were left blank.	F 318		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 32 During observation 11/06/14, at 12:22 p.m. R5 was observed to be in his wheelchair watching television in his room. During interview 11/6/14 at 1:05 p.m., RTA-A stated she was pulled to the floor due to the facility being short staffed. RTA-A stated R5 had not had a decline in her ROM. R42's last quarterly Minimum Data Set (MDS), dated 8/28/14, included diagnoses of, Alzheimer's disease, depression, and contractures of the upper extremities (including the shoulders). R42 was severely, cognitively impaired and needed extensive assistance of two staff for activities of daily living (ADLs), and was receiving restorative nursing for passive range of motions (PROM). In review of the OT (Occupational Therapy) Progress & Discharge Summary, dated 12/03/13, R42 was assessed by therapy to have restricted movement, to both her left shoulder and right wrist, at the time of admission. Occupational Therapy determined R42 should have restorative nursing to prevent further contractures, and provided the facility a restorative plan via a Therapy to restorative Nursing Communication Form (dated 12/03/13). This document provided the restorative nursing program instructions manual manipulation of shoulder with massage, flexion and extension, elbow flexion and extension, and right wrist pronation, supration, flexion, extension, and to encourage R42's participation with monitor her progress. R42's Care Plan, last reviewed for care conference on 10/29/14, indicated R42 was	F 318		

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F 318	Continued From page 33 receiving restorative nursing, with "PROM daily per therapy recommendations." During observations on 11/06/14, from 8:15 a.m. through 10:30 a.m., there were no indications that R42 had received PROM from facility staff. During an interview on 11/06/14 at 12:59 p.m., nursing assistant (NA)-B and restorative assistant (RA)-A stated that PROM had not been completed. NA-A had been pulled from the restorative nursing role, to a cover direct care position. RA-A and NA-B both stated they were not able to complete the PROM needs for R42 due to the needs of other residents on their assignments. RA-A stated the last time she performed PROM program with R42, there was no noticeable change in her abilities. Review of the Restorative Flow sheets for R42, identified the following: November 1-6, '14 - Restorative Nursing (RS) was provided only once out of 6 days. October 2014 - RS was provided 8 of 31 days September 2014 - RS was provided 5 of 30 days August 2014 - RS was provided 16 of 31 day Review of the Restorative Nursing progress notes, dated 6/18/14, 7/17/14 and 9/25/14, all indicated that R42 "tolerates the PROM without difficulties." During interview on 11/06/14 at 1:22 p.m., registered nurse (RN)-A, stated that she did not feel there had been any change in R42's contractures. RN-A stated when R42 was admitted, she had special clothing with zippers and buttons on the back due to the severity of her contractures. RN-A stated that currently, staff are	F 318		

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F 318	Continued From page 34 able to get regular tops on her, but R42 can be was resistance to cares. During interview 11/6/14, at 1:12 p.m. director of nursing (DON) stated the restorative nursing programs should be completed and if the RTA is pulled to the floor each individual nursing assistant is responsible to complete the restorative nursing on there residents. During interview 11/6/14, at 1:20 p.m. with NA-C who stated when the RTA is pulled to the floor she is unable to complete the restorative nursing because she has too much work to do. During interview 11/6/14, at 1:25 p.m. with NA-D stated she does not have the time when she is working on the floor to also complete the restorative nursing if the RTA is pulled to the floor. Although R50, R5 and R42 all have ROM programs, these programs were not being consistently implemented, even though the physical and occupational therapist identified these residents needed ROM programs to prevent a potential decline in ROM. The facility Rehabilitative Nursing Care policy revised 2007, indicated the following: "Nursing personnel are trained in rehabilitative nursing care. Our facility has an active program of rehabilitative nursing which is developed and coordinated through the resident's care plan."	F 318		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		12/15/14

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F 323	Continued From page 35 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to attach audible alarms in accordance with manufacturer's recommendations to promote safety and reduce the risk of accident hazards for 3 of 3 residents (R75, R32, R65) who were identified at risk for falls. In addition, the facility failed to provide routine safety checks for 1 of 1 residents (R37) at risk for physical injury, and was unable to use a call light to alert staff to her needs. Findings include: ALARMS NOT SECURED: R75's admission Minimum Data Set (MDS), dated 7/22/14, identified R75 had severe cognitive impairment, required extensive assistance to complete activities of daily living (ADL), and had sustained falls in the month prior to his admission to the facility. R75's care plan, dated 10/31/14, identified R71 was at high risk for falls, had severe dementia with behaviors, and required assistance with mobility. Further, the care plan indicated an intervention to reduce R71's risk of falls of, "Tab alarm on at all times." During observation on 11/5/14 at 6:51 a.m., R71	F 323	Tab alarms were secured to stationary objects. Dicem was replaced for the resident cited. All residents with Dicem care planned have been identified and have Dicem in place per care plan. Staff education re: tab alarms being secured to a stationary object to function properly and that Dicem needs to be replaced if removed has been completed and added to CNA orientation checklist for consistent training for each new hire. Placement of tab alarms and Dicem will be audited weekly x 4 weeks, then biweekly x 1 month, then quarterly throughout the following year, with results reported to the Quality Council, by Director of Nursing or designee. Documentation of routine 30 minute checks has been added to the Repositioning and Toileting sheet for the one resident with 30 minute checks. Education for Nursing staff re: importance of ensuring this resident□s safety has completed. Monitoring will be 3x weekly x 2 weeks, then weekly x 2 weeks, biweekly x 1 month, Monthly x 4 months, then quarterly throughout the following year with results reported to the Quality Council	

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F 323	Continued From page 36 was in bed sleeping. He had a TAB alarm (device features a pull-string that attaches magnetically to the alarm with a garment clip attached to the resident, so attempts to rise out of a chair / bed results in the magnet being pulled away from the alarm this causes the alarm to sound) clipped to his shirt, but the device itself was not attached to fixed structure. It was laying on the mattress to the left side of the pillow. The alarm was able to be pulled without the magnet detaching from the device, so no audible alarm was made to alert staff. When interviewed on 11/5/14 at 11:38 a.m., registered nurse (RN)-B stated the alarms required resistance to work effectively, and should be attached to a fixed structure. R71's alarm should be attached to the headboard, not laying on the mattress. Further, RN-B stated an improperly used alarm would be a safety concern for R71. During interview on 11/5/14 at 11:47 a.m., the director of nursing (DON) stated R71's alarm should be fixed to his headboard to work correctly. R32's quarterly MDS dated 8/11/14, included diagnoses of a stroke with hemiplegia (one sided paralysis) or hemiparesis (one sided weakness) and dementia, was moderately cognitively impaired, had unsteady balance, and had two falls since the previous assessment. R32's Care Area Assessment (CAA) dated 5/11/14, indicated she was at high risk for falls due to a history of falls and a recent fall in February 2014 with a wrist fracture, increased confusion and chronic pain.	F 323	by the Director of Nursing or designee.	

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F 323	Continued From page 37	F 323		

R32's care plan dated 8/20/14, indicated she was at risk for falls, had a wrist fracture from a fall in February 2014, and was more dependent on staff for activities of daily living (ADL's). Staff were instructed to ensure bed was in low position, dicem (non skid mat) under the perimeter defined mattress (a mattress with a raised edge), dicem to wheelchair, and "tabs" (a personal alarm system which has a string that attaches to the residents clothing at one end, and attached to a magnet on a box, when pulled off the magnet, an alarm sounds) alarm on at all times.

During observation 11/04/14, at 7:00 a.m. R32 was observed lying in bed with the head of the bed (HOB) elevated 30 degrees and with Personal Sentry Fall Monitoring System (PSFMS) (same alarm type as the TABs alarm) lying on the bed unsecured lying on top of the pillow. There was no dicem under the perimeter mattress or on R32's wheelchair which were both identified on the care plan.

Review of R32's Fall scene Investigation Reports indicated the following:
5/27/14, found on floor alarm used and was reaching for an object.
6/10/14, found on floor in wheelchair trying to stand up.
7/26/14, slipped onto wheelchair while standing up, alarm used, the alarm string was too long.
09/09/14, bed was not in appropriate height, found on floor, falls device was not on resident. "Staff found resident kneeling on floor next to bed. Res checked no s/s [signs and symptoms] of injury noted to arms and back. Did find dime size reddened area to res L [left] knee. Staff assisted

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F 323	Continued From page 38 res up to w/c [wheelchair]." The alarm was not on the resident. During interview 11/5/14, at 8:09 a.m. resident therapy assistant (RTA)-A verified there was no dicem in R32's wheelchair or under the mattress, and should have been. The above observation was discussed on 11/05/14, at 10:00 a.m. the director of nursing (DON) stated this "should have been investigated and the falls interventions should have been in place." R65's significant change MDS dated 10/08/14, included a diagnosis of dementia, severe cognitive impairment, required extensive assistance for transfers, and had falls since the last assessment. R65's Care Area Assessment (CAA) dated 10/08/14, indicated he has difficulty maintaining balance, was on antidepressants, had arthritis, visual and hearing impairment with impulsivity. R65's care plan dated 10/14/14, indicated he had impaired mobility r/t weakness and worsening dementia. The care plan further indicated he had interventions in place to prevent falls and had one fall out of bed since admission with minor injuries. The care plan indicated to have bed in low position, mat by bedside. R65's nursing assistant care sheet dated 11/5/14, included, tab alarm at all times, mat next to bed, and bed in low position at all times. During observation 11/05/14, at 7:00 a.m. R65 was observed to be lying in bed with tabs alarm	F 323		

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F 323	Continued From page 39	F 323		

laying on his bed, which was not secured to anything.

R65's Resident Incident Report dated 7/14/14, indicated "Resident was found laying on the floor next to bed with wheelchair across the room..." The report indicated has device but non in use, Location of device: "other side of room".

During interview 11/5/14, at 10:15 a.m. the DON stated R65's tabs alarm should have been fastened to his bed.

An un-dated Personal Sentry Fall Monitoring System User Instructions brochure indicated, "The monitor is mounted to either a chair or bed using the clip on the back of the monitor..."

A policy on alarm use was requested, but none was provided.

SAFETY CHECKS

R37's quarterly MDS dated 8/22/14, indicated mild cognitive impairment, and diagnoses which included a neurological disease with uncontrollable movements. The MDS further indicated R37 required extensive to total assistance for all ADL's (activities of daily living), including mobility.

R37's care plan dated 8/25/14, identified an injury prevention plan which included low bed with mattress, padding on the walls, no furniture near bed along and various other interventions to maintain safety for R37. The care plan also, identified R37 under vulnerabilities, to complete,

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F 323	Continued From page 40 "safety checks every 30 minutes." Review of the facility nurse progress note dated 9/15/14, at 1:45 p.m. indicated " [R37] rolled out into hallway by her door and noted to have small bloody nosebleed, unable to determine if she bumped nose on doorway." A nursing progress note, dated 11/03/2014, noted R37 was no longer able to pull tab alarm [a safety alarm]to summon staff, and was also unable to have an extended call light cord, due to safety concerns. The progress note directed that R37 was to be placed on 30 minute safety checks for safety. During continuous observation on 11/05/14 from 7:06 a.m. until 8:54 a.m., (one hour and 48 minutes), there were no facility staff that entered R37's room to check on her. During this time, R37 was behind the wall in her room, and was not visible from the hallway. Staff had to enter the room to check on her. At 8:54 a.m., nursing assistants (NA)-C and NA-E entered R37's room and announced, "We are here to start your morning cares," 1 hour and 48 minutes. During interview on 11/05/14 at 9:14 a.m., NA-C stated she was called in this morning, and "I just started working." NA-C stated NA-E helped me get R37 "ready for the day" and that "I have not checked on R37 at all today." NA-C said R37 was to be "checked every 30 minutes" according to he assignment sheets. NA-C said the the assignment sheets (for R37) were updated yesterday,"and it was hand-written." During interview on 11/06/2014 at 8:45 a.m., registered nurse (RN)-A stated R37 was	F 323		

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F 323	Continued From page 41 "supposed to be checked every 30 minutes." RN-A said R37 has been found "in the hall" and was at risk for "bruises and injuries due to her involuntary movements." RN-A stated the nursing assistants "are aware of this it is on their assignment sheets," and should be doing every 30 minutes for R37's safety.	F 323		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to allocate staff in sufficient numbers to ensure care was provided	F 353	Bath aides have been educated re: the need to reschedule baths right away if scheduling conflicts arise. New incentive	12/22/14

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F 353	Continued From page 42 to 8 of 15 residents (R16, R50, R17, R5, R32, R65, and R42) reviewed for personal cares. In addition, for 3 of 3 family members (FM-D, FM-A, and FM-B), and 5 of 6 employees (NA-D, NA-E, NA-A, NA-F, and NA-H) who had concerns about resident cares not being completed, or completed timely. Findings include: Care not provided to residents: The facility failed to provide a dignified dining experience for 2 of 4 dependent residents (R16 and R50), who were assisted to eat while staff were standing next to them and/or had to wait an extended period of time to be served the meal and receive assistance. In addition, facility staff failed to answer a call light timely for 1 of 5 residents (R6) observed during morning cares, who required assistance with toileting. Refer to F241 for further information. The facility failed to implement the care planned interventions for restorative nursing, oral care, incontinence care and/or fall prevention, for 7 of 32 residents (R17, R50, R5, R32, R65, and R42) reviewed for care plan implementation. Refer to F282 for further information. The facility failed to provide and consistently implement restorative ambulation services to improve and/or maintain the resident's ambulation ability for 1 of 3 residents (R17)	F 353	program has been developed to attract more people to the Nursing Assistant role. Staff meetings have been held to discuss staffing and staff are encouraged to bring concerns and feedback forward to be addressed. Certain positions within the Nursing department have had duties modified to allocate more hours to direct resident care. Team formed to investigate root cause analysis and explore possible solutions. Team formed to develop job description for a position to assume delegated tasks that do not require the education or registry of Nursing Assistant to perform. This role will assist Nursing staff to perform tasks such as bed-making, linen passes, water passes, waitressing, etc. to free up nursing staff to assist with direct care. For times of need, contracts have been established with staffing agencies. Direct care staffing hours are reviewed daily and adjusted accordingly based upon acuity to accommodate resident needs. Staff education related to timely meal service, need to be seated while feeding a resident, re: not cancelling a call light until the staff is able to assist that resident with their needs, and protocol for use of colored call lights has been provided, and has been added to the CNA orientation checklist for consistent teaching for each new hire. Call light wait times and timely meal service added to Resident Council agendas monthly. Staff education completed 12/15/14. Resident responses related to call lights and timely meal	

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F 353	Continued From page 43 reviewed for ambulation. Refer to F311 for further information. The facility failed to provide nursing rehabilitative services as ordered for 3 of 5 resident's (R50, R5 and R42) reviewed for rehabilitative services to maintain or increase range of motion (ROM). Refer to F318 for further information. Family concerns: R50's quarterly Minimum Data Set (MDS) dated 8/29/14, indicated cognitive impairment, and that R50 required extensive staff assistance for all activities of daily living (ADLs), including eating and bathing. In an interview on 11/3/14, at 1:28 p.m. family member (FM)-D stated he came to the facility daily, staying until after the evening meal. FM-D had concerns with the staffing ratio, and the time it takes to respond to resident needs, "The wait period can be unreal," adding that, "We have waited half an hour every time I push the light" for R50. FM-D stated he had given these concerns to the new administrator, the nursing director and social worker. "What would happen if I wasn't here?" FM-D queried. In a subsequent interview on 11/5/14, at 11:50 a.m. FM-A stated, "On weekends there can be huge delays in call light response times." FM-A stated he feels, "There are no people accountable on weekends, and they end up being	F 353	service from Resident Council will be audited monthly with reports to the Quality Council. Dining Room will be observed utilizing the Dignity portion of the Dining Observation provided by CMS (Form CMS-20053) weekly x 4 weeks, then biweekly x 1 month, then quarterly throughout the following year, with results reported to the Quality Council by Social Service Director or designee. Restorative program has been reorganized with additional staff designated to provide restorative, with two CNAs sharing the duties on AM shift and, by 12/22/14, one designated on PM shift as well. Monitoring for completion and documentation will be weekly x 4 weeks, then biweekly x 1 month, then quarterly throughout the following year, with results reported to the Quality Council. Nursing staff have been educated about the importance of providing assistance with oral cares with AM and PM cares. Monitoring of oral care completion for 10% of facility population will be weekly x 4 weeks, then biweekly x 1 month, then quarterly throughout the following year, with results reported to the Quality Council. Tab alarms were secured to stationary objects. Dicem was replaced for the resident cited. All residents with Dicem care planned have been identified and have Dicem in place per care plan. Staff education re: tab alarms being	

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F 353	Continued From page 44 short of staff." FM-A stated he felt his concerns were, "Ignored," despite talking with the administration." "I get no response." R65's significant change MDS dated 10/08/14, indicated he was severely cognitively impaired and needed extensive assistance with eating. The MDS further indicated he had gastrointestinal reflux (GERD) and hypertension. During interview 11/03/14, at 5:21 p.m., (FM)-B stated she comes to lunch and supper to assist R65 with eating. FM-B stated the staff, "Just don't have the time to feed him," and if they do, "they feed him on the run." Resident concerns: R63's quarterly MDS dated 9/23/14, indicated intact cognition, and that he required extensive assistance with mobility, transferring and ADL's. During an interview on 11/3/14, at 5:17 p.m. R63 stated he had to, "Wait for help, especially on days I have a shower." R63 stated, "Yesterday they canceled my shower because two persons call it; they never rescheduled it." R16's annual MDS, dated 7/28/14, indicated intact cognition, and that he required extensive assistance with ADLs.	F 353	secured to a stationary object to function properly and that Dicem needs to be replaced if removed. Added to CNA orientation checklist for consistent training for each new hire. Placement of tab alarms and Dicem will be audited weekly x 4 weeks, then biweekly x 1 month, then quarterly throughout the following year, with results reported to the Quality Council, by Director of Nursing or designee. Completed 12/15/14. Documentation of routine 30 minute checks has been added to the Repositioning and Toileting sheet for the one resident with 30 minute checks. Education for Nursing staff re: importance of ensuring this resident□s safety has been ongoing and will be completed by 12/15/14. Monitoring will be 3x weekly x 2 weeks, then weekly x 2 weeks, biweekly x 1 month, Monthly x 4 months, then quarterly throughout the following year with results reported to the Quality Council by the Director of Nursing or designee. Resident # 17 has since passed away. No current residents with a specialized walking program that requires specific training of staff to administer. All walking plans are implemented by CNAs. Walking programs that require specific training of staff will be administered by the CNAs and appropriate staff will be trained to assist those residents. Monitoring of completion and documentation of walking programs will be weekly x 4 weeks, then biweekly x 1 month, then quarterly throughout the	

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	245360	A. BUILDING _____ B. WING _____	11/06/2014

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F 353	Continued From page 45 During an interview on 11/3/14, at 6:55 p.m. R16 stated that often, after activating the call light, a staff, "...would turn the light off, and then would say 'someone will come in to help you', and they don't." R16 stated, "That needs to be looked into," and added the only one who should be able to turn off the light "...is the one who is giving me the help I need." R60's quarterly MDS dated 9/10/14, indicated she had anemia and hypertension. During interview 11/5/14, at 9:33 a.m. R60 stated about a month ago she did not receive her bath because they did not have enough staff. R60 then stated she had, "... wait two weeks to have my hair washed," and she was frustrated. R28's quarterly MDS, date 7/25/2014 indicated moderately impaired cognition. The MDS further identified R28 required extensive assistance with mobility, transferring, dressing, toileting and bathing. During an interview, on 11/3/14, at 1:33 p.m. R28 stated she has often had to wait, "...over 30 minutes, it is the worst in the afternoons." R28 stated she has had, "Accidents waiting for staff," and that in the past two days, "I wet myself," because her call light had not been answered timely. R6's admission MDS indicated she had intact cognition, and that she required extensive assistance with ADLs. The MDS also indicated she required total dependence for bathing. During an interview, on 11/3/14, at 7:00 p.m. R6 stated that her call light was not answered promptly, "...quite a bit." "I think they are short	F 353	following year, with results reported to the Quality Council.	

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F 353	Continued From page 46 staffed," R6 stated. R24's annual MDS, dated 9/7/14, indicated intact cognition, and that she required extensive assistance for most ADLs and bathing. In an interview on 11/3/14, at 6:02 p.m. R24 stated the facility was, "...always understaffed," and that she sometimes had to wait a long time to get up and dressed in the morning. R24 stated she has had toileting accidents and soiled herself, because staff could not assist her soon enough. R24 stated the staff shortage was not limited to any day or time, or weekend, but simply, "There is not enough people here." R48's quarterly MDS dated 10/01/14, indicated he had dementia and was severely cognitively impaired. The MDS further indicated he needed extensive assist of one with eating. During interview 11/06/14, at 12:29 p.m. R48's full time care giver (FCG)-A stated I try to come every day to help feed [R48] and to make sure he eats. The facility does not have enough staff in the dining room to assist him to eat. Employee concerns: During interview on 11/3/14, at 12:27 p.m. nursing assistant (NA)-D stated, "Short staffing happens a lot," and added the administration was aware of	F 353		

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the concerns and problems, and added, "I don't think anything is being done to help us. NA-D stated she had been a nursing assistant for a long time, and "wanted to walk out one day because it was so bad." NA-D stated residents, "...complain to us that they are being rushed."

During interview 11/05/14, at 6:50 a.m. NA-E stated the facility, "Needs more staff." NA-E further stated, many times, when the are short staffed, the bath aide "gets pulled to the floor and the resident baths don't get done." NA-E identified that [R60] recently had missed her bath due to the bath aide being pulled to the floor.

In an interview on 11/5/14, at 8:46 a.m. NA-A stated lately, "We don't have enough staff to take care of everybody." NA-A and stated the bath aides got pulled from giving baths in order to help get residents up for the day. "We are short, and struggle to get personal cares and grooming done."

During an interview on 11/5/14, at 11:28 a.m. NA-F stated there was not enough help to get all of the resident cares done. Some residents take a long time to assist and they get rushed.

During an interview on 11/5/14 at 11:50 a.m., NA-H stated, "This morning we were 'short' staffed. We were flat out short." NA-H also stated no ward clerks worked on the weekend. NA-H stated she frequently thought there was not "sufficient supervision in the dining room,

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especially at breakfast." NA-H stated she had residents who were slow eaters, who sat at different tables, and that, "I go from one to the other," standing up, so that, "all three are fed." NA-H stated it couldn't be done, "by sitting with only one resident." NA-H then stated, "I just feel sorry for the residents who are getting short-changed, and not getting the help they need."

During an interview on 11/5/2014 at 1:17 p.m., nursing assistant NA-G stated she did not feel she, "..get to spend enough quality time with the residents, when we go into their rooms." NA-G added, she felt the real issue was "getting CNAs (nursing assistants) to stay at the facility." NA-G stated on the weekends, "there is no ward clerk to assist with resident needs especially in the dining room," and that "it was up to the aides to get the residents to breakfast." NA-G stated this past weekend, "There was no breakfast served before 9:00 a.m.," and added that residents, "can't get a hot meal after 9:30 a.m." The activities staff, who were also nursing assistants, "Often assisted with dining on the weekends, taking resident orders, putting on clothing protectors," but their hours had been reduced. Float pool staff were also utilized for nursing assistants, but "they don't really know the residents," and it takes them longer to complete cares. For one of the aides, it was only, "her third day here."

During an interview on 11/6/14, at 2:39 p.m. the director of nursing (DON) stated the facility has, "looked at staffing" and that it was "very difficult to find the right mix of people to work." The DON

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F 353	Continued From page 49 stated that only, "two CNAs who went through the training class last April" have stayed. "It's a very difficult job," and "not everyone can do this job." A staffing policy was requested, but not provided by the facility.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356		11/7/14

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F 356	Continued From page 50 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to display the actual hours worked for all nursing staff on the daily staff posting. This had the potential to affect all 46 residents, staff, and any visitors who may wish to review this information. Findings include: During the initial tour of the facility, on 11/3/14, at 1:20 p.m. a Today's Staffing - Nursing Department form was displayed in the window of the main nursing office in the commons area of the building. The posting indicated disciplines of registered nurses (RN), licensed practical nurses (LPN), trained medication aides (TMA), and nursing assistant, registered (NA/R), along with each disciplines total hours worked. The posting included the designated start times for each shift (6:00 a.m., 2:00 p.m., and 10:00 p.m.), however did not identify the actual hours worked by these disciplines. Additional observations of the staff posting were made on 11/4/14, at 3:12 p.m. and 11/5/14, at 7:21 a.m. with the same posting format displayed. During interview on 11/4/14, at 2:50 p.m. the facility scheduler (FS)-A stated the bath NA/R shift is typically 5:30 a.m. to 1:30 p.m., but one day a week would come in early to complete a	F 356	Form revised to a form that contains all the elements of the form released in The Federal Register for 10/28/2005. Audits for form completion and accuracy, by Director of Nursing or designee, will be weekly for 4 weeks, monthly x 2 months, then quarterly throughout the following year with results reported to the Quality Council. Corrected 11/7/14.	

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F 356	Continued From page 51 specific bath request. The evening shift had several shifts that did not start at 2:00 p.m., including one NA/R being assigned from 2:00 p.m. to 9:00 p.m., and two NA/R's being assigned from 4:00 p.m. to 9:00 p.m.. Further, FS-A stated this was the consistent staffing schedule and had been done this way for at least a year. When interviewed on 11/6/14, at 8:29 a.m. the FS-A stated the posting was felt to be accurate, however did not accurately capture the actual shifts or hours worked for each discipline. When interviewed on 11/6/14, at 8:38 a.m. the director of nursing (DON) stated the format to display the staff posting had been in use since the previous year, and the current form did not allocate the actual hours being worked by staff. A facility policy on the staff posting was requested, but none was provided.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		11/19/14

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F 371	Continued From page 52 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure effective sanitizing of resident use dishes, to prevent the potential spread of food borne illness. This had the potential to affect 45 of 45 residents who received meals from the facility kitchen. Findings include: During the initial kitchen tour on 11/3/14, at 1:50 p.m. dietary aide (DA)-A was washing the noon meal dishes in the facility's high temperature dishwasher (Hobart-Model a.m. 15). The machines digital temperature gauge read 122 degrees Fahrenheit (F). DA-A stated this gauge was not accurate, therefore staff were using a dial gauge located on the wall, which attached to the hot water line feeding the dishwasher. This gauge read between 165-170 degrees F during the wash and rinse cycle. DA-A stated they occasionally use test strips to verify the rinse cycle reaches 180 degrees F. (160 degrees F at the rack level). DA-A then placed a TempRite Test Strip into the dishwasher, at the rack level, and completed a wash/rinse cycle. DA-A stated the test strip would turn orange if the rinse cycle reached the minimum expected temperature of 160 degrees F at the rack level. DA-A removed the test strip when the cycle was completed, but the test strip did not turn orange, identifying it did not reached 160 degree F. DA-A then ran a thermometer through the wash/rinse cycle, the maximum reading was 145 degrees F. Another thermometer was then used and read 150 degrees F.	F 371	Disposable dishware was used immediately following the discovery of the temperature problem. Faulty thermostat was replaced on 11/3/14. Wash and rinse temps are checked and recorded while the dishwasher is in use per policy. Form for recording temps has been revised and staff education has been provided related to immediate reporting of temps not within established range. Documentation audits of temp logs, by Culinary Services Director or designee, will be semiweekly x 4 weeks, then weekly x 4 weeks, then monthly throughout the following year with results reported to the Quality Council. Staff education completed 11/19/14.	

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F 371	Continued From page 53 A review of The Facility Dish Machine Temperature Logs, dated May through November 2014, revealed multiple missing fields of documentation under the heading of wash, rinse and test strip, for all three meals tested each day. During the past week, the dishwasher wash/rinse documentation was missing 15 of the 21 meal times. During interview on 11/3/14, at 2:11 p.m. the Director of Maintenance (DM) checked the temperature with his thermometer and agreed it did not meet the minimum temperature requirement. DM stated the manufacturer of the Hobart Dishwasher was no longer making replacement parts for this model of dishwasher. They were unable to get a temperature gauge from the manufacturer, so they needed to use a different temperature gauge to monitor the dishwasher temperatures. During interview on 11/3/14, at 2:16 p.m. the DM reported the booster pump in the basement was reading 175 F and the temperature gauge in the kitchen was reading 170 F. He also reported that he had put a call in to Foodservice Equipment Service to do a service call and check the equipment. On 11/3/14, at 2:21 p.m. the DM informed the kitchen staff not to use the dishwasher until further notice and to utilized disposable dishes for the evening meal. On 11/3/14, at 3:14 p.m. DM reported that Foodservice Equipment Service returned his call and would be coming out this evening to inspect	F 371		

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F 371	Continued From page 54 and repair the equipment. On 11/4/14, at 8:50 a.m. the DM stated that the Hobart dishwasher was repaired last evening. He reported there was a faulty sensor in the water heater, that caused the water heater to fluctuate heating cycles. The serviceman also replaced the electric circuit that powered the heater as several of the terminals appeared to be singed. The DM stated they ran the dishwasher after repairs last evening with the water temperature of 190 degrees F coming into the dishwasher and 163 degrees F at rack level. A TempRite test strip was tested on 11/4/14, at 9:00 a.m. and found to be orange which indicated water temperature to be over 160 degrees F at the rack level. The facility policy entitled Dishwashing Procedures, dated 4/09, included, "The temperature of the water shall be maintained at 150 F or above for the washing cycle and at 180 F for the rinsing and sanitizing cycle (160 F at the surface contact point)."	F 371		
F 425 SS=C	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services	F 425		11/19/14

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F 425	Continued From page 55 (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain emergency medications so they were available for immediate use, and not expired. This had potential for affect all 46 residents in the facility who may have required these emergency medications. Findings include: The "Refrigerator emergency kit," was observed with registered nurse (RN)-C on 11/6/14, at 12:16 p.m. A label on the kit included, lorazepam (an anti-anxiety medication) injectable(s) with a date of 4/14/14 written underneath, promethazine (a medication used to reduce nausea and allergy symptoms) suppositories with a date of 9/14/14 written underneath, and Novolog insulin with no date recorded underneath. The emergency kit was opened by RN-C, and the medications reviewed. The vials of lorazepam were confirmed to be expired as of 4/14, and the promethazine expired as of 9/14.	F 425	Expired medications were replaced. Representative(s) from pharmacy will be checking the contents of all emergency medications monthly to ensure that medication with close expiration dates are replaced prior to expiration. Consulting pharmacist will audit quarterly as well. Director of Nursing or designee will audit monthly x 3 months, then quarterly and report results to Quality Council. Corrected 11/19/14.	

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F 425	Continued From page 56 During interview on 11/6/14, at 12:16 p.m. RN-C stated the emergency kit medications are available to all residents for use in an emergency situation,and should not be expired. RN-C stated the pharmacy was responsible for checking for expired medications. When interviewed on 11/6/14,at 12:29 p.m. the director of nursing (DON) stated the emergency kits are rotated out by pharmacy, and expired medications should not be present and available for resident use. During interview on 11/6/14,at 1:22 p.m. the dispensing pharmacist (DP) at Cashwise stated the outside of the emergency kit should have all expiration dates listed for each medication, and the facility is responsible to monitor for expired medications. The DP stated the facility should have a system in place to ensure emergency medications do not expire. When interviewed on 11/6/14,at 1:35 p.m., the facility's consulting pharmacist (CP) stated they do not complete an audit of the facility emergency kit as this is the facility's responsibility. A Medication Cart/Room Inspection form completed by the CP, dated 7/29/14, identified a section labeled "EMERGENCY KIT."Further, the form identified a checkmark, with "by provider" (checked by provider) next to the heading, "Outdated, used, deteriorated, or broken items are not found." A policy on medication emergency kit management was requested, but none was provided.	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	11/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(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 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 (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.	F 441		12/4/14

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	245360	A. BUILDING _____ B. WING _____	11/06/2014

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F 441	Continued From page 58 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that gloves were used by nursing staff to provide subcutaneous medication for 1 of 8 residents (R71) whom was given insulin by the nursing staff. Findings include: R71's quarterly Minimum Data Set (MDS), dated 9/3/14, indicated R71 had diabetes mellitus (metabolic disease causing increased blood glucose levels, sometimes requiring insulin to be given), and received insulin injections daily. During observation of medication administration, on 11/5/14, at 12:33 p.m. licensed practical nurse (LPN)-A attached a needle to a Lantus insulin pen, dialed a dose of 20 units on the device, and cleansed R71's skin on his left posterior arm using an alcohol preparation pad. LPN-A then administered the medication to R71's posterior left arm. LPN-A did not wash her hands before, nor have gloves on during the cleansing of R71's skin and injection of the medication. When interviewed on 11/5/14, at 12:38 p.m. LPN-A stated she typically does not put gloves on when giving residents insulin, however it was, "probably a good idea." Further, LPN-A stated she frequently sees other staff administering insulin and not wearing gloves. During interview, on 11/5/14 at 12:42 p.m., registered nurse (RN)-B stated their was potential for contact with blood when giving insulin, and nurses should have gloves on. Further, RN-B	F 441	All licensed staff have received a copy of the policy and procedure for administering insulin injections via insulin pen. Audits of compliance with policy, by Director of Nursing or designee, will be biweekly x 1 month, then monthly x 2 months, then quarterly throughout the following year with results reported to the Quality Council. Teaching completed 12/4/14.	

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	245360	A. BUILDING _____ B. WING _____	11/06/2014

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F 441	Continued From page 59 stated not wearing gloves would pose an infection control risk as something is being injected into the body and creating an opening for infection. When interviewed on 11/6/14, at 10:27 a.m. the director of nursing (DON) stated nurses should be wearing gloves when giving insulin medication. An undated, facility Injection Pen-Subcutaneous policy indicated, "The licensed nurse is responsible to ensure safe and accurate medication administration via the subcutaneous route." Further, the policy indicated a procedure including washing of hands, and donning gloves before giving the medication.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/05/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	**100 GLEN OAKS DRIVE** **NEW LONDON, MN 56273**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS - 2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Benedictine Living Community of New London was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

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

Electronically Signed | 12/02/2014

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

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K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Benedictine Living Community of New London is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1964 and was determined to be of Type II(000) construction. In 1993 and addition was added to the south of the Service Wing that was determined to be of Type II(000) construction. In 1996 and addition was added to the north of the Service Wing that was determined to be of Type II(000) construction. In 1999 and addition was added to the south of the 1993 addition that was determined to be of Type II(000) construction. Because the original building and the 3 additions are of the same type construction the facility was surveyed as one building. The building is fully protected by a fire sprinkler system. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for	K 000		

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	245360	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/05/2014**

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K 000	Continued From page 2 automatic fire department notification. The facility has a licensed capacity of 58 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 45 residents. Findings include: On facility tour between 10:00 AM and 12:30 PM on 11/05/2014, documentation review of the weekly inspection logs Three weeks during the month of February 2014 for the gas emergency generator revealed that the weekly operational inspection were missed. This deficient practice was confirmed by the	K 144	a. Maintenance staff has been educated regarding the importance of maintaining documentation for generator testing. Maintenance will maintain Generator test documentation will be audited for each biweekly x 2, monthly x 4, then quarterly and reported on quarterly to the QA committee. b. Corrected on 11/14/14. c. Responsibility of Maintenance Director.	11/14/14

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K 144	Continued From page 3 Facility Maintenance Director (RW) at the time of discovery.	K 144		