DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		ICARE/MEDICA						ID: 93VD
1. MEDICARE/MEDICAID PROVIDER N (L1) 245623 2.STATE VENDOR OR MEDICAID NO. (L2) 103600300		3. NAME AND ADDRESS OF FACILITY (L3) BENEDICTINE LIVING CTR FRIDLEY (L4) 520 OSBORNE ROAD NORTHEAST (L5) FRIDLEY, MN			7	(L6) 55432	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation 7. On-Site Visit	Facility ID: 29890 7 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF OW (L9)	VNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7) 01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA			8. Full Survey After C				
	5/2017 (L34) 23/20 <u>17</u> (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPI	CE	FISCAL YEAR ENDING	G DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 50 (L37) (L38) 16. STATE SURVEY AGENCY REMAR Man 17. SURVEYOR SIGNATURE	19 SNF (L39) KS (IF APPLICABLE S	B. Not in Com Requirements a ICF (L42) HOW LTC CANCELL	cce With quirements Based On: cceptable POC bliance with Program ind/or Applied Waive IID (L43) ATION DATE):		2. 3. 4. 5. * Code: 15. FACILI 1861 (e) (iscontin	pproved Waivers Of The Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code <u>A*</u> TTY MEETS 1) or 1861 (j) (1): DUED OF COMPANY SURVEY AGENCY API	9. Beds/Room (L12) (L15) e 07/14/2017	vices Limit ctor
Susanne Reuss, U	Jnit Supervis	or (08/15/2017	(L19)	Kate JohnsTon, Program Specialist 09/07/2017 (L20)			
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE (OR SINGLE STAT	E AGENCY	
 DETERMINATION OF ELIGIBILIT <u>X</u> 1. Facility is Eligible to Pa <u>2</u>. Facility is not Eligible 			PLIANCE WITH CI ITS ACT:	VIL	21.		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCF	A-1513)
22. ORIGINAL DATE OF PARTICIPATION 03/18/2015 (L24)	23. LTC AGREEMI BEGINNING I (L41)		4. LTC AGREEMEN ENDING DATE (L25)		<u>VOLUNTA</u> 01-Merger, 02-Dissatisf	Closure action W/ Reimbursemer	INVOLUN 05-Fail to N	(L30) <u>TARY</u> feet Health/Safety feet Agreement
25. LTC EXTENSION DATE: (L27)	 ALTERNATIVI A. Suspension of B. Rescind Susp 	of Admissions:	(L44) (L45)			nvoluntary Termination ason for Withdrawal	<u>OTHER</u> 07-Provider 00-Active	Status Change
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C.	ARRIER NO.	(L31)	30. REMAF	RKS		
31. RO RECEIPT OF CMS-1539	32 (L32)	DETERMINATION C 07/03/2017	OF APPROVAL DAT	E (L33)	DETERM	INATION APPRO	VAL	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245623 September 7, 2017

Ms. Nicole Donahue, Administrator Benedictine Living Center Fridley 520 Osborne Road Northeast Fridley, MN 55432

Dear Ms. Donahue:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program .

Effective July 14, 2017 the above facility is certified for or recommended for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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.

Benedictine Living Center Fridley September 7, 2017 Page 2

Sincerely,

ator X opuston

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697



cc: Licensing and Certification File



Protecting, Maintaining and Improvingthe Health of All Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On, October 23, 2017

I, <u>Nicole Donahue</u>, <u>Administrator</u>, received (Name)(Please Print) (Title)(Please Print) the Notice of Penalty Assessment dated and licensing orders issued to:

> Benedictine Living Ctr Fridley 520 Osborne Road Northeast Fridley, MN 55432

The Penalty Assessments and licensing orders attached hereto have been corrected as of .

Signed: <u>Dicole Donahue</u>, <u>Administrator</u>, Date 10/23/2017 (Name)(Please Print) (Title)(Please Print)

DELIVERY OF LICENSING PENALTY ASSESSMENT NOTICE

On, October 23, 2017

I, MOMODOU L. FATTY, NURSE EVALUATOR I, of the Health Regulation Division,

(Name)(Please Print) (Title)(Please Print) Minnesota Department of Health, delivered the Notice of Penalty Assessment dated and issued to:

> Benedictine Living Ctr Fridley 520 Osborne Road Northeast Fridley, MN 55432

The Notice of Penalty Assessment was handed to <u>NICOLE</u> <u>DONAHUE</u>,

(Name)(Please Print) (Title)(Please Print) Signed: MOMODOU L. FATTY (MATY.), NURSE EVALUATOR IT (Name)(Please Print) (Title)(Please Print)



Protecting, Maintaining and Improving the Health of All Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On,			
l,	,		, received
	(Name)(Please Print) ce of Penalty Assessment dated and lic		_
	Benedictine Living Ctr Fridley 520 Osborne Road Northeast Fridley, MN 55432		
The Pena	alty Assessments and licensing orders a	ittached hereto have beer	corrected as of .
Signed:			, Date
	(Name)(Please Print)	(Title)(Please Print)	
On ,	DELIVERY OF LICENSING	G PENALTY ASSESSMENT N	NOTICE
l,			_, of the Health Regulation
Division,			
Minneso	(Name)(Please Print) ta Department of Health, delivered the		ment dated and issued to:
	Benedictine Living Ctr Fridley 520 Osborne Road Northeast Fridley, MN 55432		
The Noti		Name)(Please Print)	,
(Title)(P	, Date lease Print)		
. ,.			
Signed:	,,		, Date
	(Name)(Please Print)	(Title)(Please Print)	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	MEDICARE/MEDICA			ID: 93VD		
P	PART I - TO BE COMP	LETED BY THE	STATE	C SURVEY AGENCY	Facility ID: 29890	
1. MEDICARE/MEDICAID PROVIDER NO.	3. NAME AND ADD	RESS OF FACILITY I E LIVING CTR FR	DIDI FV		4. TYPE OF ACTION: <u>7 (</u> L8)	
(L1) 245623 2.STATE VENDOR OR MEDICAID NO.		E ROAD NORTHEA			1. Initial 2. Recertification	
(L2) 103600300	(L5) FRIDLEY, MI			(L6) 55432	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other	
 EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 	7. PROVIDER/SUPP 01 Hospital		ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint	
6. DATE OF SURVEY 08/15/2017 (L3-	4) 02 SNF/NF/Dual	06 PRTF 10	NF	14 CORF		
8. ACCREDITATION STATUS:(L10)) 03 SNF/NF/Distinct	07 X-Ray 11	ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)	
0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF	08 OPT/SP 12	RHC	16 HOSPICE	06/30	
11LTC PERIOD OF CERTIFICATION	10. THE FACILITY IS	S CERTIFIED AS:				
From (a):	X A. In Compliance	e With		And/Or Approved Waivers Of The	Following Requirements:	
To (b) :	Program Requ Compliance B			2. Technical Personnel	6. Scope of Services Limit	
	_			3. 24 Hour RN	7. Medical Director	
12.Total Facility Beds 50 (L18		ceptable POC		4. 7-Day RN (Rural SNF)	8. Patient Room Size	
13.Total Certified Beds 50 (L17	7) B. Not in Compl	liance with Program		5. Life Safety Code	9. Beds/Room	
	Requirements an	nd/or Applied Waivers:		* Code: A*	(L12)	
14. LTC CERTIFIED BED BREAKDOWN				15. FACILITY MEETS		
18 SNF 18/19 SNF 19 S	SNF ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
50 (L37) (L38) (L3	39) (L42)	(L43)				
16. STATE SURVEY AGENCY REMARKS (IF APPLICA	BLE SHOW LTC CANCELLA	TION DATE)				
		<i>.</i>	is di	iscontinued effective	07/14/2017	
Mandatory DOPNA, effective 08/24/2017, is of the surveyor signature Date :				18. STATE SURVEY AGENCY APP		
Susanne Reuss, Unit Super	rvisor	8/15/2017	(L19)	Kate JohnsTon, Pro	ogram Specialist 09/07/2017 (L20)	
PART II -	• TO BE COMPLETED	BY HCFA REGI	ONAL	OFFICE OR SINGLE STAT	E AGENCY	
19. DETERMINATION OF ELIGIBILITY		PLIANCE WITH CIVIL	-	21. 1. Statement of Financia		
_X 1. Facility is Eligible to Participate	RIGHT	IS ACT:		 Ownership/Control In Both of the Above : 	nterest Disclosure Stmt (HCFA-1513)	
2. Facility is not Eligible						
(L2	21)					
22. ORIGINAL DATE 23. LTC AGR	REEMENT 24	. LTC AGREEMENT		26. TERMINATION ACTION:	(L30)	
OF PARTICIPATION BEGINN	NING DATE	ENDING DATE		VOLUNTARY 00	INVOLUNTARY	
03/18/2015				01-Merger, Closure	05-Fail to Meet Health/Safety	
(L24) (L41)		(L25)		02-Dissatisfaction W/ Reimbursemen	nt 06-Fail to Meet Agreement	
25. LTC EXTENSION DATE: 27. ALTERN	ATIVE SANCTIONS			03-Risk of Involuntary Termination	OTHER	
A. Suspe	ension of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change	
(L27) D. B. Bassie		(L44)			00-Active	
B. Rescir	nd Suspension Date:	(L45)				
28. TERMINATION DATE:	29. INTERMEDIARY/CA	RRIER NO.		30. REMARKS		
	00000					
(L28)		(1	(L31)			
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF	F APPROVAL DATE				
(L32)	07/03/2017	(1	(L33)	DETERMINATION APPROV	VAL	

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services Midwest Division of Survey and Certification Chicago Regional Office 233 North Michigan Avenue, Suite 600 Chicago, IL 60601-5519



CMS Certification Number (CCN): 245623

June 30, 2017 ePOC and Certified Mail

Ms. Nicole Donahue, Administrator Benedictine Living Center Fridley 520 Osborne Road Northeast Fridley, MN 55432

Dear Ms. Donahue:

SUBJECT: FEDERAL MONITORING SURVEY RESULTS AND NOTICE OF IMPOSITION OF REMEDY Cycle Start Date: May 24, 2017

STATE SURVEY RESULTS

On May 23, 2017, a health survey was completed at Benedictine Living Center Fridley by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. This survey found that your facility was not in substantial compliance with the most serious deficiencies at Scope and Severity (S/S) level F, cited as follows:

- F279 -- S/S: D -- 483.20(d);483.21(b)(1) -- Develop Comprehensive Care Plans
- F325 -- S/S: D -- 483.25(g)(1)(3) -- Maintain Nutrition Status Unless Unavoidable
- F428 -- S/S: D -- 483.45(c)(1)(3)-(5) -- Drug Regimen Review, Report Irregular, Act On
- F431 -- S/S: D -- 483.45(b)(2)(3)(g)(h) -- Drug Records, Label/Store Drugs & Biologicals

The MDH advised you of the deficiencies that led to this determination and provided you with a copy of the survey report (CMS-2567).

FEDERAL MONITORING SURVEY

On June 23, 2017, a survey team representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the survey team informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found additional deficiencies, with the most serious cited as follows:

• F371 -- S/S: F -- 483.60(i)(1)-(3) -- Food Procure, Store/Prepare/Serve - Sanitary

The findings from the FMS will be posted on the ePOC system.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the enclosed deficiencies cited at the FMS. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice
- How the facility will identify other residents having the potential to be affected by the same deficient practice
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur
- The date that each deficiency will be corrected
- An electronic acknowledgement signature and date by an official facility representative

INFORMAL DISPUTE RESOLUTION (IDR)

The MDH offered you an opportunity for IDR following its survey visits. A request for IDR does not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

CMS has established an IDR process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR §488.331. To use this process, you must send your written request, identifying the specific deficiencies you are disputing to Christine Vause, Branch Manager at <u>Christine.Vause@cms.hhs.gov</u>. The request must set forth in detail your reasons for disputing each deficiency and include copies of all relevant documents supporting your position. A request for IDR will not delay the effective date of any enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care
- Remedies imposed
- Alleged failure of the surveyor to comply with a requirement of the survey process
- Alleged inconsistency of the surveyor in citing deficiencies among facilities
- Alleged inadequacy or inaccuracy of the IDR process

You must submit your request for IDR within the same ten (10) calendar day timeframe for submitting your ePOC. You must provide an acceptable ePOC for <u>all</u> cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

SUMMARY OF ENFORCEMENT REMEDIES

As a result of the survey findings we are imposing the following remedy:

• Mandatory denial of payment for new admissions effective August 24, 2017

The authority for the imposition of remedies is contained in subsections 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR § 488 Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

DENIAL OF PAYMENT FOR NEW ADMISSIONS

Mandatory denial of payment for all new Medicare admissions is imposed effective August 24, 2017, if your facility does not achieve compliance within the required three months. This action is mandated by the Act at §1819(h)(2)(D) and §1919 (h)(2)(C) and Federal regulations at 42 CFR §488.417(b). We will notify your Medicare Administrative Contractor that the denial of payment for all new Medicare admissions is effective on August 24, 2017. We are further notifying the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective August 24, 2017.

You should notify all Medicare and Medicaid residents admitted on or after this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

TERMINATION PROVISION

If your facility has not attained substantial compliance by November 24, 2017, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the Act at §1819(h) and §1919(h) and Federal regulations at 42 CFR §488.456 and §489.53.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR §489.57 will apply.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at \$1819(f)(2)(B) and \$1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a \$1819(b)(4)(C)(ii)(II) or \$1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$10,483; has been subject to a denial of payment, the appointment

of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 24, 2017, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Benedictine Living Center Fridley will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 24, 2017. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS

This formal notice imposed the following remedy:

- Mandatory denial of Payment for New Admissions effective August 24, 2017
- Mandatory Six Month Termination effective November 24, 2017

If you disagree with the findings of noncompliance which resulted in this imposition, and the finding of SQC which resulted in the loss of NATCEP approval, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR § 498.

You are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <u>https://dab.efile.hhs.gov/</u>. To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at <u>https://dab.efile.hhs.gov/user_sessions/new</u> to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking **Civil Remedies Division** on the File New Appeal screen.
- Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of

care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at **OSDABImmediateOffice@hhs.gov**.

Please note that <u>all</u> hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Nancy K. Rubenstein, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, D.C. 20201

A request for a hearing must be filed <u>no later than 60 days</u> from the date of receipt of this notice. It is important that you send a copy of your request to our Chicago office to the attention of Tamika J. Brown.

CONTACT INFORMATION

If you have any questions, please contact Tamika J. Brown, Principal Program Representative at (312) 353-1502. Information may also be faxed to (443) 380-6614.

Sincerely,

Sameria J. Brown

Tamika J. Brown Principal Program Representative Long Term Care Certification & Enforcement Branch

cc: Minnesota Department of Health Minnesota Department of Human Services Office of Ombudsman for Older Minnesotans Stratis Health



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 7, 2017

Ms. Nicole Donahue, Administrator Benedictine Living Center Fridley 520 Osborne Road Northeast Fridley, MN 55432

RE: Project Number S5623002

Dear Ms. Donahue:

On June 12, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 24, 2017. The most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On June 23, 2017, a surveyor representing the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The FMS 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).

On June 30, 2017, the Centers for Medicare & Medicaid Services informed you that the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 24, 2017. (42 CFR 488.417 (b))

Also, they notified you in their letter of June 30, 2017, 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 August 24, 2017.

On August 15, 2017, the Minnesota Departments of Public Safety and 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 May 24, 2017 and a Federal Monitoring Survey (FMS) completed June 23, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 14, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 24, 2017, and our FMS completed on June 23, 2017, as of July 14, 2017.

Benedictine Living Center Fridley September 7, 2017 Page 2

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 June 30, 2017. 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 August 24, 2017, 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 August 24, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective August 24, 2017, is to be rescinded.

In our letter of June 30, 2017, 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 August 24, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 14, 2017, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

ate Comston

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

: Licensing and Certification File

CC:



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Electronically Delivered on September 7, 2017. September 7, 2017

Ms. Nicole Donahue, Administrator Benedictine Living Center Fridley 520 Osborne Road Northeast Fridley, MN 55432

Re: Project # S5623002

Dear Ms. Donahue:

On August 15, 2017, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 24, 2017.

State licensing orders issued pursuant to the last survey completed on May 24, 2017, found not corrected at the time of this August 15, 2017 revisit and subject to penalty assessment are as follows:

21426 -- S/S: -- MN St. Statute 144A.04 Subd. 3 -- Tuberculosis Prevention And Control

The details of the violations noted at the time of this revisit completed on August 15, 2017 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of \$0.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to , Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, Po Box 64900 St Paul Mn 55164-0900.

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added

Benedictine Living Ctr Fridley September 6, 2017 Page 2

to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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.

Sincerely,

ato Johnston

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

cc: Licensing and Certification File Shellae Dietrich, Licensing and Certification Program Penalty Assessment Deposit Staff



Protecting, Maintaining and Improving the Health of All Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On,			
l,	,		, received
	(Name)(Please Print) ce of Penalty Assessment dated and lic		_
	Benedictine Living Ctr Fridley 520 Osborne Road Northeast Fridley, MN 55432		
The Pena	alty Assessments and licensing orders a	ittached hereto have beer	corrected as of .
Signed:			, Date
	(Name)(Please Print)	(Title)(Please Print)	
On ,	DELIVERY OF LICENSING	G PENALTY ASSESSMENT N	NOTICE
l,			_, of the Health Regulation
Division,			
Minneso	(Name)(Please Print) ta Department of Health, delivered the		ment dated and issued to:
	Benedictine Living Ctr Fridley 520 Osborne Road Northeast Fridley, MN 55432		
The Noti		Name)(Please Print)	,
(Title)(P	, Date lease Print)		
. ,.			
Signed:	,,		, Date
	(Name)(Please Print)	(Title)(Please Print)	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMIT					ГAL	ID: 93VD					
	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVE	YAGE	NCY		Fa	acility ID: 29890	
1. MEDICARE/MEDICAID PROVIDER NO (L1) 245623	0.	3. NAME AND AD (L3) BENEDICTI	NE LIVING CTH	R FRIDLEY	Z			4. TYPE OI 1. Initial	F ACTION:	<u>2 (</u> L8) 2. Recertification	on
2.STATE VENDOR OR MEDICAID NO. (L2) 103600300		(L4) 520 OSBORNE ROAD NORTHEAST (L5) FRIDLEY, MN			(L6) 55432		3. Termination 5. Validation 7. On-Site Visit		4. CHOW 6. Complaint 9. Other		
5. EFFECTIVE DATE CHANGE OF OWN (L9)	NERSHIP	7. PROVIDER/SUI 01 Hospital	PPLIER CATEGORY 05 HHA	Y 09 ESRD	<u>02</u> 13 PTIP	(L7)	22 CLIA		visit		
6. DATE OF SURVEY 05/24/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2017 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSP			FISCAL YEA	R ENDING 1 / 30	DATE: (I	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:								
From (a): To (b):		A. In Complian Program Re Compliance	quirements Based On:		2 3	. Technie . 24 Hou	cal Personnel ır RN	7. M	ope of Servio edical Direct	or	
12. Total Facility Beds	50 (L18)	I. P	Acceptable POC				RN (Rural SNF		tient Room S	ize	
13. Total Certified Beds	50 (L17)		pliance with Program and/or Applied Waiv		5 * Code:		ifety Code	9. Be (L12)	eds/Room		
14. LTC CERTIFIED BED BREAKDOWN					15. FACIL	LITY ME	ETS				
18 SNF 18/19 SNF 50	19 SNF	ICF	IID		1861 (e)	(1) or 18	61 (j) (1):	(I	.15)		
(L37) (L38)	(L39)	(L42)	(L43)								
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELI	LATION DATE):		<u> </u>						
17. SURVEYOR SIGNATURE		Date :			18. STATE	E SURVE	Y AGENCY A	PPROVAL		Date:	
Mary Heim, H	FE NE II		06/21/2017	(L19)	Kate.	John	sTon, Pr	ogram Sp	ecialist	07/03/20	17 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RH	EGIONAL	OFFICE	OR SI	NGLE STAT	TE AGENCY			
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part			IPLIANCE WITH C HTS ACT:	IVIL	21.	2. Ow		cial Solvency (HCF Interest Disclosure	,	-1513)	
2. Facility is not Eligible	leipute					3. DUI	in of the Above				
2. Taking is not English	(L21)										
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	24. LTC AGREEME	INT	26. TERM	MINATIC	ON ACTION:		(L	.30)	
OF PARTICIPATION 03/18/2015	BEGINNING	DATE	ENDING DATI	Ξ	<u>VOLUNTA</u> 01-Merger,				INVOLUNTA	<u>ARY</u> et Health/Safety	
(L24)	(L41)		(L25)				V/ Reimbursem	ent (06-Fail to Me	et Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATIVI A. Suspension of						ry Termination Withdrawal	(Status Change	
(L27)	B. Rescind Sus	nension Date:	(L44)					(00-Active		
	B. Reschid Sus	pension Date.	(L45)								
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMA	RKS					
		00000									
	(L28)			(L31)							
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DAT	ſE	Postec	1 07/03/	/2017 Co.				
	(L32)			(L33)	DETERM	MINAT	ION APPRO	OVAL			



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 12, 2017

Ms. Nicole Donahue, Administrator Benedictine Living Center Fridley 520 Osborne Road Northeast Fridley, MN 55432

AMENDED LETTER: This letter has been redacted. It replaces the letter dated June 8, 2017.

RE: Project Number S5623002

Dear Ms. Donahue:

On May 24, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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:

Susanne Reuss, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900 susanne.reuss@state.mn.us Telephone: (651) 201-3793 Fax: 651-215-9697

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 July 3, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Benedictine Living Center Fridley June 12, 2017 Page 4

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 August 24, 2017 (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 Benedictine Living Center Fridley June 12, 2017 Page 5 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 November 24, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

> Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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

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

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. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525 Benedictine Living Center Fridley June 12, 2017 Page 6

Feel free to contact me if you have questions.

Sincerely,

Katol Tomoton

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 8, 2017

Ms. Nicole Donahue, Administrator Benedictine Living Center Fridley 520 Osborne Road Northeast Fridley, MN 55432

RE: Project Number S5623002

Dear Ms. Donahue:

On May 24, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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;

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<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.

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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 [Compliance Due Date()], the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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Benedictine Living Center Fridley June 8, 2017 Page 4

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

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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

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Benedictine Living Center Fridley June 8, 2017 Page 5

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 [Cycle Start + 6 Months()] (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:

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

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Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Benedictine Living Center Fridley June 8, 2017 Page 6

> Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

¥ atot Inston

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	. 0938-0391
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245623	B. WING			05/	24/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	TINE LIVING CTR FF	RIDLEY			20 OSBORNE ROAD NORTHEAST RIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	FC	000			
F 279 SS=D	standard survey wa the Minnesota Depa if your facility was in requirements of 42 Requirements for L The facility's plan o as your allegation of Department's accep enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you validate that substar regulations has bee your verification. 483.20(d);483.21(b) COMPREHENSIVE 483.20 (d) Use. A facility n assessments comp months in the resid results of the assess and revise the resic plan. 483.21 (b) Comprehensive	CFR Part 483, Subpart B, and ong Term Care Facilities. f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance. acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with)(1) DEVELOP E CARE PLANS nust maintain all resident oleted within the previous 15 ent's active record and use the asments to develop, review dent's comprehensive care	F2	279			7/3/17
	•	son-centered care plan for					
	DIRECTOR'S OR PROVIE	DER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE	_	(X6) DATE 06/16/2017
	ically Signed						00/10/2017

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

PRINTED: 06/21/2017

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245623	B. WING	i		05/2	24/2017
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE LIVING CTR FF	RIDLEY			520 OSBORNE ROAD NORTHEAST FRIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	each resident, cons set forth at §483.10 includes measurab to meet a resident's and psychosocial n comprehensive ass care plan must des (i) The services tha or maintain the resi physical, mental, ar required under §48 (ii) Any services tha under §483.24, §48 provided due to the under §483.10, incl treatment under §4 (iii) Any specialized rehabilitative servic provide as a result recommendations. findings of the PAS rationale in the resi (iv)In consultation v resident's represen (A) The resident's g desired outcomes. (B) The resident's p future discharge. Fa whether the resider community was ass	sistent with the resident rights (c)(2) and §483.10(c)(3), that le objectives and timeframes a medical, nursing, and mental eeds that are identified in the sessment. The comprehensive cribe the following - t are to be furnished to attain dent's highest practicable ad psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative (s)- goals for admission and preference and potential for acilities must document it's desire to return to the sessed and any referrals to ies and/or other appropriate	F	279			

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	<u> SFOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		ייסו			0938-039 SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245623	B. WING			05/2	24/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE LIVING CTR FF	RIDLEY			20 OSBORNE ROAD NORTHEAST RIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 279	Continued From pa	ige 2	F 2	79			
	plan, as appropriate requirements set for section. This REQUIREMEN by: Based on interview facility failed to deven nutritional risk for 2 R129) reviewed for Findings include: The facility failed to nutrition care plan f R315's care area a revealed R315 was poor diet compliand R315's current orde "Diet: Diabetic, Low renal/dialysis" and ' ml/day" and "Start F supplement 30 ml F added protein." and guest is receiving V meals Twice a Day binder that helps pr levels of calcium in phosphorus. Review of the care revealed no probler services. There was qualified dietitian w how coordination re	e develop a comprehensive for R315. assessment, dated 1/17/17, and dialysis and was at risk for			The Preparation of the following pla correction for this deficiency does n constitute and should not be interpri as an admission nor an agreement facility of the truth of the facts allege conclusions set forth in the stateme deficiencies. The plan of correction prepared for this deficiency was exe solely because it is required by prov of State and Federal law. Without we the foregoing statement, the facility 1) With respect to R315; a comprehe nutrition care plan has been develop based on the nutritional assessmen input from R315 which includes: frequency of Registered Dietician re coordination between facility and dia center; and Guest's non-compliance 2) With respect to R129; a comprehe care plan has been developed base Guest's Nutritional assessment with from R129 which includes intervention prevent unintentional weight loss ar maintain fluid balance. 3) All Guests have the potential to b affected. 4) The facility care plan policy and procedures were reviewed. The	ot eted by the ed on ent of ecuted visions waiving states: hensive ped it with eview, alysis e. hensive ed on input ions to nd	

Facility ID: 29890

If continuation sheet Page 3 of 24

STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
		245623	B. WING _		05/	24/2017
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	P CODE	
BENEDI	CTINE LIVING CTR F	RIDLEY		520 OSBORNE ROAD NORTHEA FRIDLEY, MN 55432	ST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 279	non compliant with individualized intervi- compliance. R315's recommendations a addressed. R315's discharge p revealed instruction precautions and ind supplements. A dialysis center ID POC [plan of care] (prior to R315's addreviewed. No intervi- skilled nursing facil noted. R315 was no an updated IDT Pa dated 5/15/17 and admission to facility "unstable." Concern potassium levels and supplement consur- taking Velphoro wit On 5/22/17 at 6:21 (RD)-A, revealed R only a few days ago expect a comprehe developed within 2" reported all dialysis considered at high review nutrition stat dialysis dietician at a nutrition care plan issues. RD-A reveal	 15's care plan noted R315 was fluid restrictions. No ventions were noted to address is level of compliance with diet and supplements were not blan of care, dated 2/11/17, his related to diet order, dicated R315 had no T [interdisciplinary] patient Meeting Report, dated 8/29/16 mission to the facility), was ventions specific to how the ity should care for R315 were oted to be "Stable" A review of tient POC Meeting report, faxed on 3/23/17 (after R315's y) revealed R315 was ns were noted with elevated nd compliance with renal diet, mption, fluid management and 	F 27	 Registered Dietician will for ensuring each Guest assessment and care plapolicy. 5) The Director of Clinica designee will audit three for one month and then t week for two months to a compliance with our care 6) The data collected from be presented to the facili (QC) by the Director of C and/or designee and disc monthly QC meetings for The QC will make the decision/recommendatio necessary follow-up stud 7) Corrective action will b July 3, 2017. 	has a nutritional in in place per al Nutrition and/or Guests per week wo Guests per ensure plan policy. In the audits will ty Quality Council linical Nutrition cussed during three months. In regarding any ies.	

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		AND HUMAN SERVICES				FORM	06/21/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
		245623	B. WING			05/2	24/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE LIVING CTR FF	RIDLEY			20 OSBORNE ROAD NORTHEAST RIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	On 5/22/17 at 6:43 (RN)-B, reported the could find was the of reported the dialysis nutrition care plan. patient plan of care On 5/23/17 at 10:23 dietician, (RD)-B, re- non-compliance wit taking the Velphoro During an observation observed R129 eati R129's room while at the bed. R129 ate boots and or swa R129's Nutrition Card dated 3/24/17, iden risk and read, " A as would be e/b: ch anorexia, abnormal breakdown, and del cause: electrolyte in increased risk of sk weakness, and weig directed a care plan developed to avoid R129's care plan da indicated alteration secondary to sepsis Staphylococcus aur abscess granuloma	 a. p.m., the nursing manager, ie only nutrition care plan she discharge care plan. RN-B s center also had their own RN-B pointed out the dialysis s. a. a.m., the dialysis center eported R315 had issues with th diet, fluid restrictions and b. ion on 5/23/17 at 8:49 a.m., ing breakfast independently in sitting in wheelchair next to breakfast without difficulty in allowing the food and drinks. are Area Assessment (CAA) tified R129 was at nutritional At risk for poor diet tolerance toking, wt (weight) loss I labs, constipation, skin hydration. Dehydration can mbalance, poor skin turgor, sin breakdown, constipation, ght fluctuations." The CAA n considerations to be complications. ated 3/28/17 and 4/6/17, in health maintenance s MRSA (Methicillin-resistant reus) in wound intraspinal a. However, the care plan did nal risk and interventions to 	F	279			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/21/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245623	B. WING			05/2	24/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE LIVING CTR FF	RIDLEY		-	20 OSBORNE ROAD NORTHEAST RIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279 F 325 SS=D	On 5/23/17 at 1:01p (RN)-C verified that including care plan dehydration/fluid ma admission MDS trig verified R129 exper stated, the expectar and dehydration/flui should be in place. On 5/23/17 at 1:12 plan lacked nutrition dehydration/fluid ma dietician was suppor nutritional status an maintenance. Policy and procedur AND PROCEDURE "1. Each departmer information on adm Individual Guest ca admission. This car necessary care of th comprehensive care team will continue ta and data over the n comprehensive care strengths and depe a guest's stay is lon comprehensive care electronic medical r 483.25(g)(1)(3) MA UNLESS UNAVOID (g) Assisted nutritio (Includes naso-gasi	b.m., the registered nurse R129's medical record lacked nutritional status and aintenance even though the igered the CAAs. RN-C tienced a weight loss. RN-C tion was a nutritional status id maintenance care plan p.m., RN-D verified that care hal status and aintenance and stated used to do the care plan for id dehydration/fluid re titled CARE PLAN POLICY dated 04/17, directed staff, it will gather needed ission to provide data for the re Plan within 24 hours of re plan will serve to direct the he guest until the e plan is completed. 2. The o collect additional information ext 14 days and will develop a e plan that contains both ndencies. 3. In the event that iger than 30 days the e plan will be entered into the record and printed." INTAIN NUTRITION STATUS DABLE		279			7/3/17

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CENTER STATEMENT AND PLAN C	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER CTINE LIVING CTR FF SUMMARY STA	TEMENT OF DEFICIENCIES	A. BUILD B. WING ID	S S F	FC OMB E CONSTRUCTION (X3) TREET ADDRESS, CITY, STATE, ZIP CODE 20 OSBORNE ROAD NORTHEAST RIDLEY, MN 55432 PROVIDER'S PLAN OF CORRECTION	ORM A NO. ()) DATE COMPI	4/2017 (X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
F 325	enteral fluids). Base comprehensive ass ensure that a reside (1) Maintains accep status, such as usu body weight range a the resident's clinicat this is not possible of indicate otherwise; (3) Is offered a ther nutritional problem orders a therapeution orders a therapeution this REQUIREMEN by: Based on observate review, the facility failed by: Based on observate review, the facility failed to services were provid 3 residents (R315 a nutrition. Findings include: The facility failed to services provided for R315's care area a revealed [R315's] w [R315's] wt of 189.6 large wt changes d/ osteomyelitis, let ar IV fluids. Wt change dialysis tx [treatmer between 184-198# 172-190# at the hose diabetic diet with sn	scopic jejunostomy, and ed on a resident's ressment, the facility must ent- table parameters of nutritional al body weight or desirable and electrolyte balance, unless al condition demonstrates that or resident preferences apeutic diet when there is a and the health care provider c diet. NT is not met as evidenced ion, interview and document ailed to ensure nutrition ded to meet the needs for 2 of and R129) reviewed for	F3	325	The Preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by facility of the truth of the facts alleged of conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was execut solely because it is required by provisio of State and Federal law. Without waive the foregoing statement, the facility sta 1) With respect to R315; a comprehenen nutrition care plan has been developed based on the nutritional assessment we input from R315 which includes: frequency of Registered Dietician revie coordination between facility and dialys center; and Guest's non-compliance. Nurses will administer Velphoro as ordered. Guests refusals will be documented and Velphoro will not be left	ed the on of uted ons iving ates: hsive d vith ew, sis	

Facility ID: 29890

If continuation sheet Page 7 of 24

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	· · /	E SURVEY PLETED
		245623	B. WING			05/2	24/2017
IAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	CTINE LIVING CTR FF	RIDLEY			20 OSBORNE ROAD NORTHEAST RIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 325	Continued From pa	ae 7	F 3	325			
	restriction] on 1/19/	(17. Culinary provides 750 ml es 750 ml/day. [R315] is able			in room.		
	to feed [R315] with for poor diet tolerar	tray set-up at meals. At risk			2) With respect to R129; a compre care plan has been developed bas Guest's nutritional assessment with	ed on	
	calorie malnutrition constipation, skin b], anorexia, abnormal labs, reakdown, and dehydration. use: electrolyte imbalance,			from R129 which includes interven prevent unintentional weight loss a maintain fluid balance.	tions to	
	breakdown, constip fluctuations. Mainta	bation, weakness's, and weight ain current level of functioning." ation the dietician completing			3) All Guests have the potential to affected.	be	
	section for "input fro	et with R315 for input. The om resident and/or /e regarding the care area"			4) The facility care plan policy and procedures were reviewed and rev implementation. The Registered D will be responsible for ensuring eac Guest has a nutritional assessment)ietician ch	
	"Diet: Diabetic, Low renal/dialysis" and ' ml/day" and "Start I	ers, printed 5/23/17, included v cholesterol/low fat and "Start fluid restriction's of 1500 Prosource nutritional			care plan per policy based on input Guests that includes individual nut needs, special diets and non-comp	ritional pliance.	
	added protein." and guest is receiving V meals Twice a Day	PO QD [orally every day] for d "Per dialysis make sure /elphoro within 20 minutes of " Velphoro is a phosphate			5) Nurses will receive re-education facility guidelines for medication administration.		
		revent hypocalcemia (low the blood) caused by elevated			6) The Director of Clinical Nutrition designee will audit three Guest's m records per week for one month ar two Guest's medical records per w	nedical nd then	
	revealed no probler	plan, updated 5/12/17, ms, goals related to nutrition s no indication how often a			two months to ensure compliance.7) The data collected from the aud	its will	
	qualified dietitian we how coordination re status would occur dialysis center. R31	ould review R315's status or elated to R315's nutrition between the facility and 15's care plan noted R315 was			be presented to the facility Quality (QC) by the Director of Clinical Nut and/or designate and discussed du monthly QC meetings fro three mo	Council trition uring	
	individualized interv	fluid restrictions. No ventions were noted to address s level of compliance with diet			The QC will make the decision/recommendation regardin necessary follow-up studies.	ig any	

Facility ID: 29890

If continuation sheet Page 8 of 24

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY
		BERTH IONTICITY TOWNEDER.	A. BUILDI	NG	001	
		245623	B. WING _			24/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 520 OSBORNE ROAD NORTHEAST		
BENEDI	CTINE LIVING CTR FR	IDLEY		FRIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETI DATE
F 325	addressed. R315's discharge pl revealed instruction precautions and ind supplements. A dialyisis center ID POC [plan of care] I (prior to R315's adm reviewed. No interve skilled nursing facili noted. R315 was no an updated IDT Pat dated 5/15/17 and f admission to facility "unstable." Concerr potassium levels ar supplement consun taking Velphoro with Review of R315's p May 2017, revealed a qualified dietician. at 7:33 p.m. The oth noted as a late entre R315's Weekly Rou center, dated 5/23/1 following abnormal nitrogen, high potas low hemoglobin. We and post treatment revealed weight char	Ind supplements were not lan of care, dated 2/11/17, s related to diet order, icated R315 had no T [interdisciplinary] patient Meeting Report, dated 8/29/16 hission to the facility), was entions specific to how the ty should care for R315 were bied to be "Stable" A review of ient POC Meeting report, axed on 3/23/17 (after R315's) revealed R315 was is were noted with elevated id compliance with renal diet, hption, fluid management and in meals.	F 3	25 8) Corrective action will be July 3, 2017.	completed by	

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			0	FORM MB NO.	06/21/2017 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245623	B. WING			05/3	24/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE LIVING CTR FF	RIDLEY		-	20 OSBORNE ROAD NORTHEAST RIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 325	only a few days age expect a comprehe developed within 2 ⁻ reported all dialysis considered at high review nutrition stat dialysis dietician at a nutrition care plan issues. RD-A revea nutrition care plan, On 5/22/17 at 5:38 R315's floor noted compliance related On 5/22/17 at 5:50 assistant, (NA)-A, r non-compliance rel restrictions. On 5/22/17 at 6:42 reported residents of they wanted. R315 ordered diet. On 5/22/17 at 6:43 (RN)-B, reported th could find was the of reported the dialysis nutrition care plan. patient plan of care On 5/22/17 at 9:22 a.m finished most of his getting the Velphore	 b. RD-A reported she would ensive nutrition care plan to be 1 days of admission. R315 a residents would be nutrition risk and an RD would tus and communicate with the least monthly. R315 reported in should address compliance aled she was not aware of a but would develop one. p.m., the registered nurse on R315 had concerns with to diet and fluid restrictions. p.m., R315's nursing evealed R315 had issues with ated to diet and fluid p.m., the dietary aide (DA)-A, were allowed to order what was not always compliant with p.m., the nursing manager, e only nutrition care plan she discharge care plan. RN-B s center also had their own RN-B pointed out the dialysis 	F	325			

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CENTER STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				FORM MB NO. (X3) DATE	06/21/2017 APPROVED 0938-0391 E SURVEY PLETED
		245623	B. WING			05/	24/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/2	24/2017
BENEDIC	CTINE LIVING CTR FF	RIDLEY		5	20 OSBORNE ROAD NORTHEAST RIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 325	asked about them. more remained in a table. R315 had a c cantaloupe on the b On 5/23/17 at 10:23 dietician, (RD)-B, re non-compliance wit taking the Velphoro communication with she had difficulty co called. RD-B report in with the facility R with other skilled nu was speaking with p updates from the fa During an observati observed R129 eati R129's room while the bed. R129 at b chewing and or swa R129's physician or " Continue Levaq Doxycycline 100 mg (every) 12 hours co 12 hours" Dated 5/1 po BID (twice a day dated 5/9/17, read, disease): guest has Doxycycline would provider" R129's admission m dated 3/21/17, iden intact, independent on a therapeutic dise	R315 took 2 brown pills, yet a medication cup on the tray cup of fruit, including preakfast tray. 3 a.m., the dialysis center eported R315 had issues with th diet, fluid restrictions and b. RD-B reported she had little in the dietician at the facility as ponnecting with one when she red typically she would check ID each month when working ursing facilities. However, she primarily only nursing to get	F	325			

Facility ID: 29890

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		AND HUMAN SERVICES				FORM	06/21/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245623	B. WING _			05/;	24/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE LIVING CTR FF	RIDLEY			20 OSBORNE ROAD NORTHEAST RIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	mellitus, pneumonia R129's progress no read, "The Infectiou doctor) called today Vibramycin for the g Minocycline 100mg C/O (complain of) r needed) dose of Zo C/O nausea and it v C/O nausea and it v C/O nausea. Dress AM (morning). Blist Serous drainage no removed. Area clea ordered." R129's Nutrition Ca dated 3/24/17, iden risk and read, " A as would be e/b: ch anorexia, abnormal breakdown, and de cause: electrolyte ir increased risk of sk weakness, and wei directed a care plar developed to avoid R129's electronic m record (EMAR) and administration reco April and May 2017 orders for nutritiona R129's weight on 4, Weight on 5/18/17	a and respiratory failure. the and respiratory failure. a and respiratory failure. but a bisease MD (medical y, D/Ced (discontinued) the guest, and ordered PO BID. Guest continues to hausea. Gave PRN (as ofran at 1215 (12:15 p.m.) for was effective in decreasing the sing to right L/E changed this thered area remains open. bed on dressing that was ansed and redressed as are Area Assessment (CAA) tified R129 was at nutritional At risk for poor diet tolerance toking, wt (weight) loss I labs, constipation, skin hydration. Dehydration can mbalance, poor skin turgor, sin breakdown, constipation, ght fluctuations." The CAA n considerations to be complications. medication administration d electronic treatment rd (eTAR) was reviewed for 7. The medical record lacked	F 3	25			

Facility ID: 29890

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		AND HUMAN SERVICES				FORM	06/21/2017 APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245623	B. WING			05/;	24/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE LIVING CTR FF	RIDLEY			20 OSBORNE ROAD NORTHEAST RIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 325	R129's care plan da indicated alteration secondary to sepsis Staphylococcus aur abscess granuloma not address nutritio prevent weight loss On 5/23/17 at 9:01 [R129] lost weight u the way [R129] lost swell throat and ant that made [R129] lost swell throat and ant that made [R129] lost on 5/23/17 at 9:55 stated have not see time and does not k R129 feels down ar On 5/23/17 at 10:39 (RN)-G R129 startet together by infection experiencing nause changed. On 5/23/17 at 10:55 (RD) stated R129 a was having IV fluids weight gain, and the On 5/23/17 at 1:01p R129's medical rec nutritional status an maintenance even triggers the CAAs a stated, expectation	ated 3/28/17 and 4/6/17, in health maintenance s MRSA (Methicillin-resistant reus) in wound intraspinal a. However, the care plan did nal risk and interventions to a	F3	225			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
			B. WING				
	PROVIDER OR SUPPLIER	245623	D. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	05/2	24/2017
NAME OF I	-noviden on sofflien				20 OSBORNE ROAD NORTHEAST		
BENEDI	CTINE LIVING CTR FF	RIDLEY		-	RIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325 F 356	On 5/23/17 at 1:12 plan lacked nutrition dehydration/fluid ma dietician was suppo nutritional status an maintenance. 483.35(g)(1)-(4) PC	p.m., RN-D verified that care nal status and aintenance and stated used to do the care plan for	F 3 F 3				7/3/17
SS=C	INFORMATION 483.35 (g) Nurse Staffing Ir (1) Data requirement the following inform (i) Facility name. (ii) The current date (iii) The total number by the following cate unlicensed nursing resident care per sh (A) Registered nurse (B) Licensed practic vocational nurses (a (C) Certified nurse a (iv) Resident censu (2) Posting requirem (i) The facility must specified in paragra	nformation ents. The facility must post ation on a daily basis: e. er and the actual hours worked egories of licensed and staff directly responsible for nift: nes. cal nurses or licensed as defined under State law) aides. s.					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM /	06/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	SURVEY PLETED
		245623	B. WING			05/2	24/2017
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE LIVING CTR FR	IDLEY			20 OSBORNE ROAD NORTHEAST RIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 356	 (ii) Data must be point (A) Clear and reada (B) In a prominent presidents and visito (3) Public access to The facility must, up make nurse staffing for review at a cost standard. (4) Facility data reternational facility must maintain staffing data for a mrequired by State la This REQUIREMENT by: Based on observation potential to affect al facility and visitors. Findings include: During observation posted Staffing Hou display was dated 5 On 5/21/17, at 12:4 hours report was ob 	ention requirements. The inimum of 18 months, or as w, whichever is greater. NT is not met as evidenced ion, interview and document ailed to post the required nation daily. This had the I 49 residents residing in the state of 5/21/17, at 8:46 a.m. the ins report for Nursing for public (17/17, with a census of 48. 7 p.m. the 5/21/17, the staffing	F 3	856	The Preparation of the following pla correction for this deficiency does n constitute and should not be interpre- as an admission nor an agreement facility of the truth of the facts allege conclusions set forth in the stateme deficiencies. The plan of correction prepared for this deficiency was exe solely because it is required by prov of State and Federal law. Without v the foregoing statement, the facility 1) With respect to posting Nurse Sta Information; the actual hours worke completed and posted on 5/21/2017 2) The Staffing Coordinator received re-education regarding the requirem for posting the Nurse Staffing Inform daily.	ot eted by the ed on nt of ecuted <i>r</i> isions vaiving states: affing d were 7. d nent	

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	S FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		. 0938-039 E SURVEY
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COM	IPLETED
		245623	B. WING _		05/	24/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
BENEDI	TINE LIVING CTR F	RIDLEY		520 OSBORNE ROAD NORTHEAST FRIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 356	administrator state was responsible for report at the begins administrator indicat through Friday, not SC, and was inform posting staffing hor stated the SC will be the weekend and the would be responsible hours report and up changes. During interview or stated she works M posts the staffing how the postings should week. SC further in be posted daily on Friday, Saturday, and weekend nurse sup with any staffing char The undated facility policy indicated nur posted "in conform The Staffing Coord for completing the Changes on the po- the shift."	a 5/23/17, at 1:26 p.m. the d the staffing coordinator (SC) r posting the staffing hours hing of the day. The ated the SC worked Monday weekends, had spoken to the ned there was no process for urs. The administrator further be posting them on Friday for he weekend nurse supervisor ole to post each daily staffing pdate them with any staffing pdate them with any staffing the display case board for and Sunday, and indicated the bervisor would up-date them hanges. y's Posting of Staffing Hours rsing staffing hours would be ity with CMS requirements" linator/Designee is responsible form on a daily basis 2. bated form will be made during	F 35	 3) The facility policy for post staffing information has bee and revised for implementat 4) All associated staff will reeducation on the facility polin Nurse Staffing Information. 5) The Administrator and/or audit the posting for accurate timeliness two times per we months to ensure compliance 6) The data collected from the presented to the Quality by the Administrator and/or and the data will be reviewed/di during monthly QC meetings months. The QC will make decision/recommendation renecessary follow-up studies 7) Corrective action will be of July 3, 2017. 	n reviewed ion. ceive cy for posting designee will cy and ek for three ce. he audits will Council (QC) designee. scussed s for three the egarding any	
F 428 SS=D	REPORT ÍRRÉGÚ		F 42	ö		7/3/17
	c) Drug Regimen F	Review				
	(1) The driver reasing	en of each resident must be				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245623	B. WING			05/2	24/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 20 OSBORNE ROAD NORTHEAST		
BENEDIC	TINE LIVING CTR FF	IDLEY			RIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428	 brain activities asso and behavior. Thes limited to, drugs in t (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist to the attending phy facility's medical dir and these reports m (i) Irregularities including the section for (ii) Any irregularities during this section for (iii) Any irregularities during this review m separate, written re attending physician director and directo minimum, the reside and the irregularity (iii) The attending p resident's medical re irregularity has been action has been tak be no change in the physician should do the resident's medical 	drug is any drug that affects bociated with mental processes se drugs include, but are not the following categories: d must report any irregularities visician and the ector and director of nursing, nust be acted upon. ude, but are not limited to, any criteria set forth in paragraph or an unnecessary drug. a noted by the pharmacist nust be documented on a port that is sent to the and the facility's medical r of nursing and lists, at a ent's name, the relevant drug, the pharmacist identified. hysician must document in the record that the identified n reviewed and what, if any, the net o address it. If there is to a medication, the attending bocument his or her rationale in	F 4	28			
	be no change in the physician should do the resident's media	e medication, the attending ocument his or her rationale in cal record.					

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		. 0938-039 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:				IPLETED
		245623	B. WING		05/	24/2017
IAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		
BENEDIC	TINE LIVING CTR F	RIDLEY		520 OSBORNE ROAD NORTH FRIDLEY, MN 55432	EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 428	Continued From pa	ige 17	F 4	28		
		the monthly drug regimen but are not limited to, time				
		rent steps in the process and				
	steps the pharmaci	st must take when he or she				
	to protect the reside	arity that requires urgent action				
		NT is not met as evidenced				
	by:	and the second table to the second		The December of the	felle les de set	
		nt review and interview, the plete monthly consultant		The Preparation of the correction for this defic		
		and act upon pharmacy		constitute and should r		
		for 1 of 5 residents reviewed,		as an admission nor a		
	procedures which p	he faciity failed to develop		facility of the truth of th conclusions set forth ir		
		ne consultant pharmacist, the		deficiencies. The plan		
		(DON) and physician and		prepared for this defici		
	all residents at the	his had the potential to impact facility.		solely because it is req of State and Federal la the foregoing statemer	w. Without waiving	
	Findings include:			1) With respect to R19	-	
		ing Minimum Data Set (MDS) sion date of 2/24/17.		was completed by the 3/31/2017.		
	pharmacist reviewe	otes revealed consultant ed R193's record on 3/31/17, nd 5/11/17. No consultant		2) All Guests have the affected.	potential to be	
	pharmacist reviews	were provided indicating were reviewed within 30 days		 The facility policy ar following up on consult recommendations was revised. 	tant pharmacist	
	three recommenda and 4/29/17. The 4 "This resident has b	t Recommendations revealed tions dated 4/3/17, 4/17/17 /3/17 recommendation noted been on Pepcid. I could not		4) All staff associated will receive re-education pharmacy reviews.		
		for this medication in the ould you please circle the		5) The Director of Nurs	sing and/or	
		ing continued proton pump		designee will audit two for one month and the	Guests per week	

		AND HUMAN SERVICES					APPROVE 0938-039
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245623	B. WING _			05/2	24/2017
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE LIVING CTR F	RIDLEY		520 FR			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIOI DATE
F 428	discontinuation?" (famotidine, a media the stomach and for stomach produces recommendation me resident is receiving BID [twice daily] Ref falls***& hospitalization included warnings in benzodiazepines in impairment, delirium motor vehicle accio guidance included, necessary, please of risk vs. benefit." A 4 a repeated recommendation physician. There was physician noted. R193's physician p signed by the R193's revealed current or 20 mg (milligrams) diazepam 2.5 mg to Review of R193's re nurse practitioner p 4/10/17, 4/13/17, 4/ and 5/17/17 revealed pharmacist recommendations, 4/29/17. DON repo	Pepcid is also called cation used to treat ulcers in or conditions where the too much acid.) The 4/17/17 oted "This 89 Y.O [year old] g (benzodiazepine): Diazepam ecent H/O [history of] of ation" The recommendation including "In general, all brease risk of cognitive m, falls***, fractures, and dents in older adults." The "If use of this medication is document an assessment of 4/29/17 recommendation was nendation related to Pepcid. ons were addressed to R193's as no response from the rogress notes, electronically 8's physician on 5/17/17, ders for famotidine (Pepcid) tablet twice daily and wice daily. ecord, including physician and progress notes, dated 4/3/17, /21/17, 4/24/17, 5/2/17, 5/9/17, ed no indication the consultant nendations were reviewed or a.m., the director of nursing e chart with surveyor. No	F 4:		 week for two months to ensure compliance. 6) The data collected from the aud be presented to the facility Quality (QC) by the Director of Nursing ar designee and discussed during m QC meetings for three months. T will make the decision/recomment regarding any necessary follow-up studies. 7) Corrective action will be compled July 3, 2017. 	Council nd/or onthly he QC dation	

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		AND HUMAN SERVICES				FORM	06/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245623	B. WING			05/2	24/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	TINE LIVING CTR FF	IDLEY		-	20 OSBORNE ROAD NORTHEAST RIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	change should be r On 5/24/17 at 9:00 (RN)-B reported sh to the April 2017 co recommendations. On 5/24/17 at 11:37 pharmacist reported marked as urgent, I pharmacist recomm the next physician of within 30 days. The Pharmacy Rec dated 12/14, directer review on each gue monthly by a licens pharmacist will repor- Director of Nursing designee will contain pharmacist's time r "immediately", "with reports will be acted (2)-The Director of are not required to "acceptance" or "re must, however, act be accomplished in indicating acceptan and signing their na response is docume pharmacy book loca	and address whether or not a nade. a.m., the nurse manager e could not find any follow up nsultant pharmacist 7 a.m. the consultant d, unless concerns were he would expect consultant nendations to be acted upon at or nurse practitioner visit or commendations procedure, ed staff "1. A drug regimen est will be performed at least ed pharmacist. 2. The ort any irregularities to the Services. The DON and/or ct the physician per the	F 4	28	DEFICIENCY)		
	Medical Director for	an will be directed to the r review. 6. The Medical findings to the Quality					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	06/21/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245623	B. WING		05/	24/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	TINE LIVING CTR FF	RIDLEY		20 OSBORNE ROAD NORTHEAST FRIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428	the attending physic the Medical Directo Services and/or des	tee. Any further follow-up with cian will be the responsibility of r or the Director of Nursing signee."	F 428			
F 431 SS=D	LABEL/STORE DR The facility must produgs and biological them under an agre §483.70(g) of this p unlicensed personn law permits, but onl supervision of a lice (a) Procedures. A fipharmaceutical ser that assure the acci- dispensing, and adr biologicals) to meet (b) Service Consult employ or obtain the pharmacist who (2) Establishes a sy disposition of all con- detail to enable an acci- (3) Determines that	art. The facility may permit el to administer drugs if State y under the general ensed nurse. acility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident. ation. The facility must e services of a licensed rstem of records of receipt and ntrolled drugs in sufficient accurate reconciliation; and drug records are in order and all controlled drugs is	F 431			7/3/17
		als used in the facility must be ce with currently accepted les, and include the				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM): 06/21/2017 / APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION (X3) DA	TE SURVEY MPLETED
		245623	B. WING	ì		/24/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
BENEDIC	CTINE LIVING CTR FF	RIDLEY			520 OSBORNE ROAD NORTHEAST FRIDLEY, MN 55432	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	applicable. (h) Storage of Drug (1) In accordance w the facility must stol locked compartment controls, and permiting have access to the (2) The facility must permanently affixed controlled drugs list Comprehensive Druc Control Act of 1976 abuse, except when package drug distril quantity stored is m be readily detected. This REQUIREMENT by: Based on observat review, the facility far were dated when op (R321) on 1 of 4 un failed to ensure 29 of gauze were removed 2 medication storage This had the potent prescribed an occlur of the 49 residents of if a physician ordered was admitted to the occlusive adaptive of Findings include:	e expiration date when s and Biologicals. vith State and Federal laws, re all drugs and biologicals in nts under proper temperature t only authorized personnel to keys. t provide separately locked, I compartments for storage of ed in Schedule II of the ug Abuse Prevention and and other drugs subject to n the facility uses single unit bution systems in which the inimal and a missing dose can NT is not met as evidenced ion, interview and document ailed to ensure medications bened for 1 of 7 residents its (Rhapsody Boulevard) and of 65 occlusive adaptive ed from the stock supply in 1 of ge rooms after having expired. ial to affect 0 residents risive adaptive guaze and any currently residing at the facility ed the occlusive adaptive e residents; or if a resident e facility with an order for the gauze.	F	431	The Preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waivin the foregoing statement, the facility states 1) With respect to R321; the open, undated insulin pen was destroyed. 2) All Guests who receive insulin through an insulin pen have the potential to be	9
	On 5/21/17, at 8:38	a.m. the medication cart for			affected.	

Facility ID: 29890

		& MEDICAID SERVICES			OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · ·	E SURVEY PLETED
		245623	B. WING _		05/2	24/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE LIVING CTR F	RIDLEY		520 OSBORNE ROAD NORTHEAST FRIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 431	of 7 insulin pens or opened. Licensed p at this time the Nov R321 and was not of A review of the med was admitted on 5/ indicated R321 was N in the morning ar On 5/24/17, at 7:30 Xeroform Occlusive have expired on 3/ date of the Xeroform nurse (RN)-B. On 5/24/17, at 10:0 (DON) stated some pharmacy had beer and had not mention Xeroform strips hav insulin was not date provided a Med Ro 5/17/17, and the for medication storage refrigerator had beer return. The expired on the form. On 5/24/17, at 10:3 pharmacist stated h registered nurse wh room inspection to considered the Xer of the review. Or if	rd was reviewed. In the cart, 1 vials were not dated when oractical nurse (LPN)-A verified rolin N insulin pen was for dated when opened. dical record revealed R321 9/17, and physician orders a receiving 37 units of Novolin and 32 units in the evening. a.m. 29 of 65 stock supply e Gauze strips were noted to 17. At 8:00 a.m. the expiration m was verified with registered 00 a.m. the director of nurses cone from the consulting n in the facility 1-2 weeks prior oned anything about the ving been expired 3/17 or that ed when opened. The DON om Inspection form dated rms indicated expired items in room cabinets and en removed for destruction or Xeroform was not addressed 05 a.m. the consulting ne would check with the no had conducted the med determine if she would have oform a medication, and part checking the Xeroform for tething the nursing department	F 4:	 3) Facility will review and revise procedures for medication laber storage. 4) All staff associated with this pre-education regarding the polic procedures for medication/biold labeling and storage. 5) The Director of Nursing and/designee will complete an audit Guests who currently use insuli random audits thereafter; two n and one med room will be audit week for one month and then o cart and one med room will be week for two months to ensure compliance. 6) The data collected from thes will be presented to the facility Council (QC) by the Director of and/or designee and discussed during QC meetings for three m The QC committee will make th decision/recommendation reganecessary follow-up studies. 7) Corrective action will be com July 3, 2017. 	ing and will receive ey and gics or on all n pens and ned carts ed per ne med audited per e audits Quality Nursing monthly ionths. e rding any	

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		AND HUMAN SERVICES			FORM	06/21/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245623	B. WING		05/:	24/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
BENEDI	CTINE LIVING CTR FF	RIDLEY		520 OSBORNE ROAD NORTHEAST FRIDLEY, MN 55432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431	surveyor and stated registered nurse wh inspection and left a if the Xeroform is no be a nursing and no review for expiration On 5/24/17, betwee RN-C, RN-E stated any resident who w On 5/24/17, at 1:05 would check the Xe expiration date befo DON stated here w staff checking treat dates. The DON als with RN-B, RN-C an any resident had us and 5/24/17. The D RN-E told her no re received the Xerofo The facility's 10/22/ Storage in the Facil not address the dat By the time of the e had not called back conducted the med	onsulting pharmacist called the d he placed a call to the ho did the med room a message. He is thinking that ot a medication then it would ot a pharmacy requirement to n. en 10:45 to 11:00 a.m. RN-B, I they currently did not have vas using the Xeroform gauze. 5 p.m. the DON stated a nurse eroform packaging for the ore using the product. The vas no policy regarding nursing ment products for expiration so stated she had checked nd RN-E as to whether or not sed the Xeroform between 4/1 DON stated RN-B, RN-C and esidents during that time period	F 43			

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	MENT OF HEALTH	AND HUMAN SERV	ICES	-	F5623002		05/31/2017 APPROVED
	S FOR MEDICARE					OMB NO.	0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			LE CONSTRUCTION 3 01 - BENEDICTINE LIVING CENTER	(X3) DATE SUF COMPLET	
		245623		B. WING		05/24	/2017
NAME OF P	ROVIDER OR SUPPLIER				TATE, ZIP CODE		
BENEDI	CTINE LIVING CTR	FRIDLEY		BORNE RO Y, MN 554	DAD NORTHEAST 432		
(X4) ID		ATEMENT OF DEFICIENCI		ID	PROVIDER'S PLAN OF CORRECT		(X5) COMPLETION
PREFIX TAG		F BE PRECEDED BY FULL INTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)		DATE
K 000	INITIAL COMMENT	rs		K 000			
	FIRE SAFETY						
	A Life Safety Code	Survey was conduct	ed by the				
		nent of Public Safety					
		on. At the time of this /e Suites of Fridley v					
	in compliance with	the requirements for					
		licare/Medicaid at 42 Life Safety from Fire					
	2012 edition of Nat	ional Fire Protection					
) Standard 101, Life ter 19 Existing Healtl					
		·					
		ve Suites of Fridley is basement. The buildi		i i i			
		4 and was determine					
		a full fire sprinkler s					
		i with smoke detection noke barrier doors, r					
	rooms and spaces	open to the corridor	that is				
	notification.	matic fire departmen	t				
		censed capacity of 5 of 48 at the time of t					
	The requirement an MET.	t 42 CFR Subpart 48	3.70(a) is				
~							
LABORATO	RY DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRES	ENTATIVE'S SIC	INATURE	TITLE		(X6) DATE

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 8, 2017

Ms. Nicole Donahue, Administrator Benedictine Living Center Fridley 520 Osborne Road Northeast Fridley, MN 55432

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5623002

Dear Ms. Donahue:

The above facility was surveyed on May 21, 2017 through May 24, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

Benedictine Living Ctr Fridley June 8, 2017 Page 2

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susanne Reuss, Unit Supervisor at (651) 201-3793 or Susanne.Reuss@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

Minnesc	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		29890	B. WING		05/2	4/2017
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BENEDI	CTINE LIVING CTR FF		ORNE ROAD MN 55432	NORTHEAST		
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2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 06/16/17

Electronically Signed

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If continuation sheet 1 of 22

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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BENEDI	CTINE LIVING CTR F		BORNE ROAD I Y, MN 55432	NORTHEAST		
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	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available fo indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.				
	surveyors of this De above provider and orders are issued. electronic plan of c	5/22/17, 5/23/17 and 5/24/17 epartment's staff, visited the I the following correction Please indicate in your orrection that you have ers, and identify the date whe ted.				
 	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are after the statement evidence by." Follo	number appears in the far left O Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMN "PROVIDER'S PLA	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 555	MN Rule 4658.040 Plan of Care; Deve	5 Subp. 1 Comprehensive lopment	2 555		7/3/	17
	must develop a cor each resident within completion of the c assessment as def comprehensive pla by an interdisciplina attending physician responsibility for the appropriate staff in the resident's need practicable, with the	elopment. A nursing home mprehensive plan of care for n seven days after the omprehensive resident ined in part 4658.0400. The n of care must be developed ary team that includes the n, a registered nurse with e resident, and other disciplines as determined by s, and, to the extent e participation of the resident, guardian or chosen				
	by: Based on interview facility failed to dev	ent is not met as evidenced and document review, the elop a care plan for assessed of 3 residents (R315 and nutrition.		Acknowledged.		
	Findings include:					
	The facility failed to nutrition care plan f	develop a comprehensive for R315.				
		assessment, dated 1/17/17, on dialysis and was at risk fo	r			

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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2 555	Continued From pa	ige 3	2 555			
	poor diet compliance.					
	"Diet: Diabetic, Low renal/dialysis" and " ml/day" and "Start I supplement 30 ml I added protein." and guest is receiving V meals Twice a Day binder that helps pr levels of calcium in phosphorus. Review of the care revealed no problet services. There wa qualified dietitian w how coordination re status would occur dialysis center. R31 non compliant with individualized intervicements	ers, printed 5/23/17, included v cholesterol/low fat and "Start fluid restriction's of 1500 Prosource nutritional PO QD [orally every day] for d "Per dialysis make sure /elphoro within 20 minutes of " Velphoro is a phosphate revent hypocalcemia (low the blood) caused by elevated plan, updated 5/12/17, ms, goals related to nutrition s no indication how often a ould review R315's status or elated to R315's nutrition between the facility and 15's care plan noted R315 was fluid restrictions. No ventions were noted to address s level of compliance with diet and supplements were not				
	R315's discharge p revealed instructior	lan of care, dated 2/11/17, is related to diet order, dicated R315 had no				
	POC [plan of care] (prior to R315's adr reviewed. No interv skilled nursing facil noted. R315 was no an updated IDT Pa	T [interdisciplinary] patient Meeting Report, dated 8/29/16 mission to the facility), was rentions specific to how the ity should care for R315 were oted to be "Stable" A review of tient POC Meeting report, faxed on 3/23/17 (after R315's				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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2 555	Continued From pa	age 4	2 555			
	admission to facility) revealed R315 was "unstable." Concerns were noted with elevated potassium levels and compliance with renal diet, supplement consumption, fluid management and taking Velphoro with meals. On 5/22/17 at 6:21 p.m., the facility dietician (RD)-A, revealed RD-A had started at the facility only a few days ago. RD-A reported she would expect a comprehensive nutrition care plan to be developed within 21 days of admission. R315 reported all dialysis residents would be considered at high nutrition risk and an RD would review nutrition status and communicate with the dialysis dietician at least monthly. R315 reported a nutrition care plan should address compliance issues. RD-A revealed she was not aware of a nutrition care plan, but would develop one.					
			1			
	(RN)-B, reported th could find was the reported the dialysi	B p.m., the nursing manager, ne only nutrition care plan she discharge care plan. RN-B is center also had their own RN-B pointed out the dialysis e.				
	dietician, (RD)-B, r	3 a.m., the dialysis center eported R315 had issues with th diet, fluid restrictions and 5.				
	observed R129 eat R129's room while the bed. R129 ate	tion on 5/23/17 at 8:49 a.m., ting breakfast independently in sitting in wheelchair next to breakfast without difficulty in allowing the food and drinks.				
	R129's Nutrition Ca					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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2 555	Continued From pa	age 5	2 555			
	 dated 3/24/17, identified R129 was at nutritional risk and read, " At risk for poor diet tolerance as would be e/b: choking, wt (weight) loss anorexia, abnormal labs, constipation, skin breakdown, and dehydration. Dehydration can cause: electrolyte imbalance, poor skin turgor, increased risk of skin breakdown, constipation, weakness, and weight fluctuations." The CAA directed a care plan considerations to be developed to avoid complications. R129's care plan dated 3/28/17 and 4/6/17, indicated alteration in health maintenance secondary to sepsis MRSA (Methicillin-resistant Staphylococcus aureus) in wound intraspinal abscess granuloma. However, the care plan did not address nutritional risk and interventions to prevent weight loss. 					
	(RN)-C verified that including care plan dehydration/fluid m admission MDS trig verified R129 expe stated, the expecta	p.m., the registered nurse t R129's medical record lacked nutritional status and paintenance even though the ggered the CAAs. RN-C rienced a weight loss. RN-C tion was a nutritional status id maintenance care plan				
	plan lacked nutritio dehydration/fluid m	aintenance and stated osed to do the care plan for				
	AND PROCEDURI "1. Each departme	re titled CARE PLAN POLICY E dated 04/17, directed staff, nt will gather needed hission to provide data for the	(

If continuation sheet 6 of 22

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55 Continued From page 6		2 555				
necessary care of the comprehensive care team will continue the and data over the recomprehensive care strengths and dependent of the comprehensive care electronic medical suggest's stay is low comprehensive care electronic medical SUGGESTED MET registered dietitian revise policies and the comprehensive individual resident is dietitian or designer educate staff and comprehension.	the guest until the re plan is completed. 2. The to collect additional information next 14 days and will develop a re plan that contains both endencies. 3. In the event that nger than 30 days the re plan will be entered into the record and printed." THOD OF CORRECTION: The or designee could review and procedures related to ensuring a nutrition care plan for each is developed. The registered e could develop a system to develop a monitoring system to					
(21) days.		2 965			7/3/17	
-Nutritional Status Subpart. 2. Nutrition must ensure that a which supplies the determined by the assessment. Subs	onal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident stitutes of similar nutritive value					
	T OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER CTINE LIVING CTR FI SUMMARY ST/ (EACH DEFICIENC) REGULATORY OR L Continued From pa Individual Guest ca admission. This ca necessary care of f comprehensive can team will continue and data over the r comprehensive can strengths and depe a guest's stay is lon comprehensive can electronic medical SUGGESTED MET registered dietitian revise policies and the comprehensive individual resident dietitian or designe educate staff and c ensure nutrition pla followed. TIME PERIOD FO (21) days. MN Rule 4658.060 -Nutritional Status Subpart. 2. Nutritic must ensure that a which supplies the determined by the assessment. Subs must be offered to	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29890 29890 PROVIDER OR SUPPLIER STREET AL 520 OSB FRIDLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 Individual Guest care Plan within 24 hours of admission. This care plan will serve to direct the necessary care of the guest until the comprehensive care plan is completed. 2. The team will continue to collect additional information and data over the next 14 days and will develop a comprehensive care plan that contains both strengths and dependencies. 3. In the event that a guest's stay is longer than 30 days the comprehensive care plan will be entered into the electronic medical record and printed." SUGGESTED METHOD OF CORRECTION: The registered dietitian or designee could review and revise policies and procedures related to ensuring the comprehensive nutrition care plan for each individual resident is developed. The registered dietitian or designee could develop a system to educate staff and develop a monitoring system to ensure nutrition plans of care are developed and followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING:	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: 29890 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 2 555 Individual Guest care Plan with 24 hours of admission. This care plan will serve to direct the necessary care of the guest until the comprehensive care plan is completed. 2. The team will continue to collect additional information and data over the next 14 days and will develop a comprehensive care plan that contains both strengths and dependencies. 3. In the event that a guest's stay is longer than 30 days the comprehensive care plan will be entered into the electronic medical record and printed." SUGGESTED METHOD OF CORRECTION: The registered dicitian or designee could review and revise policies and procedures related to ensuring the comprehensive nutrition care plan for each individual resident is developed and followed. 2 965 TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 2 965 Subpart. 2. Nutritional status. The nursing home must be offered to residents who refuse food 2 965	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: (X2) MUTIPILE CONSTRUCTION A BUILDING: (X3) DATA A BUILDING: ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES INTRE LIVING CTR FRIDLEY STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES REQUARTORY OR LSC IDENTIFYING INFORMATION) IDENTIFICATION NUMBER: FRIDLEY, MN 55432 Continued From page 6 2 555 Individual Guest care Plan within 24 hours of admission. 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SUGGESTED METHOD OF CORRECTION: The registered dietitian or designee could review and revise policies and procedures related to ensuring the comprehensive nutrition care plan for each individual resident is developed and followed. 2 965 MN Rule 4658.0	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
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	This MN Requirem by:	ent is not met as evidenced				
	Based on observat review, the facility f services were prov	ion, interview and document ailed to ensure nutrition ided to meet the needs for 2 and R129) reviewed for	of	Acknowledged.		
	Findings include:					
		The facility failed to ensure adequate nutrition services provided for R315.				
	revealed [R315's] w [R315's] wt of 189. large wt changes d osteomyelitis, let at IV fluids. Wt chang dialysis tx [treatme between 184-198# 172-190# at the ho diabetic diet with sr Dialysis added a 18 restriction] on 1/19, and nursing provide to feed [R315] with for poor diet tolerar [evidenced by]: cho calorie malnutrition constipation, skin b Dehydration can ca poor skin turgor, in breakdown, constip fluctuations. Mainta There was no indice the assessment mo	assessment, dated 1/17/17, vt [weight] increased 0.8# fro 6# on 1/4/17. [R315] has hac /t edema, following: sepsis, nkle amputation, dialysis, and les are expected between nt]. [R315's] wts ranged since admit and between spital. [R315] receives a rena hacks offered between meals 500 ml [milliliter] FR [fluid /17. Culinary provides 750 m les 750 ml/day. [R315] is able tray set-up at meals. At risk hace as would be e/b oking, wt loss, PCM [protein], anorexia, abnormal labs, breakdown, and dehydration. ause: electrolyte imbalance, creased risk of skin bation, weakness's, and weig ain current level of functioning eation the dietician completing et with R315 for input. The	htt			
	section for "input fr	om resident and/or ve regarding the care area"				

STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		29890	B. WING		05/	05/24/2017	
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2 965	2 965 Continued From page 8 R315's current orders, printed 5/23/17, included "Diet: Diabetic, Low cholesterol/low fat and renal/dialysis" and "Start fluid restriction's of 1500 ml/day" and "Start Prosource nutritional supplement 30 ml PO QD [orally every day] for added protein." and "Per dialysis make sure guest is receiving Velphoro within 20 minutes of meals Twice a Day" Velphoro is a phosphate binder that helps prevent hypocalcemia (low levels of calcium in the blood) caused by elevated phosphorus.		2 965				
	revealed no proble services. There wa qualified dietitian w how coordination re status would occur dialysis center. R3 non compliant with individualized inter- compliance. R315's	plan, updated 5/12/17, ms, goals related to nutrition is no indication how often a rould review R315's status or elated to R315's nutrition between the facility and 15's care plan noted R315 was fluid restrictions. No ventions were noted to address s level of compliance with diet and supplements were not					
	revealed instruction	blan of care, dated 2/11/17, ns related to diet order, dicated R315 had no					
	POC [plan of care] (prior to R315's add reviewed. No interviewed. No interviewed. No interviewed. skilled nursing facilinoted. R315 was n an updated IDT Pa dated 5/15/17 and	DT [interdisciplinary] patient Meeting Report, dated 8/29/16 mission to the facility), was ventions specific to how the lity should care for R315 were oted to be "Stable" A review of tient POC Meeting report, faxed on 3/23/17 (after R315's y) revealed R315 was					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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IAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE		
BENEDIC	CTINE LIVING CTR F	RIDLEY	BORNE ROAD I EY, MN 55432	NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 965	Continued From pa	ige 9	2 965			
	"unstable." Concerns were noted with elevated potassium levels and compliance with renal diet, supplement consumption, fluid management and taking Velphoro with meals.					
	May 2017, revealed a qualified dietician	orogress notes for January to d 2 nutrition follow up notes b . One was written on 5/22/17 her was written on 5/23/17 a ry for 5/18/17.	ру ,			
	center, dated 5/23/ following abnormal nitrogen, high potas low hemoglobin. W and post treatment revealed weight cha	unding Sheet from the dialysi 17 revealed the recent lab results: high blood urea ssium, high phosphorous and eight changes between pre for 5/12/17 to 5/22/17 anges between -2.0 kg 8 kg, or -2.2% to 12.8%.				
	(RD)-A, revealed R only a few days age expect a comprehe developed within 2 reported all dialysis considered at high review nutrition stat dialysis dietician at a nutrition care plan issues. RD-A revea	p.m., the facility dietician D-A had started at the facility o. RD-A reported she would ensive nutrition care plan to b 1 days of admission. R315 residents would be nutrition risk and an RD wou tus and communicate with th least monthly. R315 reported n should address compliance led she was not aware of a but would develop one.	e Id e			
	R315's floor noted	p.m., the registered nurse or R315 had concerns with to diet and fluid restrictions.				
	assistant, (NA)-A, r	p.m., R315's nursing evealed R315 had issues wit ated to diet and fluid	th			

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		29890	B. WING		05/	24/2017
IAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
BENEDIC	TINE LIVING CTR FI		ORNE ROAD I , MN 55432	NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 965	Continued From pa	age 10	2 965			
	restrictions.					
	reported residents they wanted. R315 ordered diet. On 5/22/17 at 6:43 (RN)-B, reported th could find was the reported the dialysi	p.m., the dietary aide (DA)-A, were allowed to order what was not always compliant with b p.m., the nursing manager, he only nutrition care plan she discharge care plan. RN-B s center also had their own				
	nutrition care plan. RN-B pointed out the dialysis patient plan of care. On 5/22/17 at 7:28 p.m., R315 reported no services were provided by a facility dietician until sometime later during the previous week. On 5/23/17 at 9:22 a.m., R315 reported he had finished most of his meal. When asked about					
	getting the Velphor R315 almost forgot asked about them. more remained in a	o with meals, R315 reported t to take them until surveyor R315 took 2 brown pills, yet a medication cup on the tray cup of fruit, including				
	dietician, (RD)-B, re non-compliance wit taking the Velphore communication with she had difficulty co called. RD-B report in with the facility R with other skilled no	3 a.m., the dialysis center eported R315 had issues with th diet, fluid restrictions and b. RD-B reported she had little h the dietician at the facility as ponnecting with one when she ted typically she would check RD each month when working ursing facilities. However, she primarily only nursing to get acility for R315.				
inesota De	During an observat	tion on 5/23/17 at 8:49 a.m.,				

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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
BENEDIC	CTINE LIVING CTR FI	RIDIEY	BORNE ROAD I Y, MN 55432	NORTHEAST		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 965	Continued From pa	age 11	2 965			
	R129's room while the bed. R129 ate l chewing and or swa R129's physician o " Continue Levaq Doxycycline 100 m (every) 12 hours co 12 hours" Dated 5/ po BID (twice a day dated 5/9/17, read, disease): guest has	ting breakfast independently in sitting in wheelchair next to breakfast without difficulty in allowing the food and drinks. rders dated 4/23/17, indicated quin through 4/29 start g (milligram) po (by mouth) q ontinue Rifampin 300 mg po q 1/17 reads, "Start Zofran 4 mg y)" In addition, physician order , "Please update ID (infection s loss of appetite since start d like alternate or f/u with	,			
da in or al	dated 3/21/17, ider intact, independent on a therapeutic dia anemia, multidrug-	minimum data set (MDS), ntified R129 was cognitively t after set up with eating, was et, and noted diagnosis of resident organism, diabetes a and respiratory failure.				
	read, "The Infection doctor) called today Vibramycin for the Minocycline 100mg C/O (complain of) n needed) dose of Zo C/O nausea and it C/O nausea. Dress AM (morning). Blist Serous drainage no	otes dated 5/11/17 at 3:54 p.m us Disease MD (medical y, D/Ced (discontinued) the guest, and ordered g PO BID. Guest continues to nausea. Gave PRN (as ofran at 1215 (12:15 p.m.) for was effective in decreasing the sing to right L/E changed this tered area remains open. oted on dressing that was ansed and redressed as				
	dated 3/24/17, ider	are Area Assessment (CAA) ntified R129 was at nutritional At risk for poor diet tolerance				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		29890	B. WING		05/2	24/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
BENEDIC	CTINE LIVING CTR F		ORNE ROAD /, MN 55432	NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 965	2 965 Continued From page 12					
	anorexia, abnorma breakdown, and de cause: electrolyte i increased risk of sl weakness, and we	noking, wt (weight) loss Il labs, constipation, skin ehydration. Dehydration can mbalance, poor skin turgor, kin breakdown, constipation, ight fluctuations." The CAA n considerations to be I complications.				
	record (EMAR) and administration record	nedication administration d electronic treatment ord (eTAR) was reviewed for 7. The medical record lacked al supplement.				
	Weight on 5/18/17	I/20/17 was 232 pounds. was 209 pounds (which was n the first date or a 11.0%				
	indicated alteration secondary to sepsi Staphylococcus au abscess granulom	lated 3/28/17 and 4/6/17, in health maintenance is MRSA (Methicillin-resistant ireus) in wound intraspinal a. However, the care plan did onal risk and interventions to S.				
	[R129] lost weight the way [R129] los	a.m., R129 indicated that unintentional and did not prefe t the amount of weight due to tibiotic that [R129] was taking ose appetite.	r			
	stated have not se time and does not R129 feels down a	a.m., nursing assistant (NA)-E en R129 eat much for a long know the reason but maybe nd sad or depressed.	3			
	On 5/23/17 at 10:3 epartment of Health	9 a.m. registered nurse				
ATE FORI	-		6899 Q ?	3VD11	If continuati	on sheet 13 c

	VT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		29890	B. WING		05/	05/24/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE	1		
BENEDI	CTINE LIVING CTR FF	RIDLEY	ORNE ROAD N MN 55432	ORTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 965	 (RN)-G R129 starter together by infectio experiencing nauser changed. On 5/23/17 at 10:55 (RD) stated R129 a was having IV fluids weight gain, and the On 5/23/17 at 1:01p R129's medical reconstringers the CAAs a stated, expectation dehydration/fluid m be in place. On 5/23/17 at 1:12 plan lacked nutritional status ar maintenance. SUGGESTED MET registered dietitian policies and proced residents receive nare gistered dietitian staft regarding thes records for complia procedures. 	ed on Doxycycline and rifampin n disease doctor and was ea from it, which was then 5 a.m., registered dietician idmitted from the hospital and s that could also cause the en started losing weight. b.m., RN-C verified that ord including care plan lacked id dehydration/fluid though the admission MDS and resident lost weight. RN-C was nutritional status and aintenance care plan should p.m., RN-D verified that care hal status and aintenance and stated bsed to do the care plan for	2 965				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION ()	(3) DATE SURVEY COMPLETED
		29890	B. WING		05/24/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE	
BENEDIC	CTINE LIVING CTR FI	RIDLEY	ORNE ROAD (, MN 55432	NORTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET
21426	Continued From pa	ige 14	21426		
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426		7/3/17
	infection control pro current tuberculosis issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implement	hensive tuberculosis ogram according to the most is infection control guidelines d States Centers for Disease htion (CDC), Division of hation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of the technical assistance intation of the guidelines. ance with this subdivision must he nursing home.			
	by: Based on interview facility failed to doc tuberculosis (TB) s of 5 residents (R21 reviewed for TB sci failed to document given for 1 of 5 em screening.	ent is not met as evidenced and document review, the ument complete results of the kin (TST) that was given for 5 7, R257, R222, R125, R315) reening. In addition, the facility complete results of the TST ployees (E3) reviewed for TB		Acknowledged.	
	Findings include:				
	R247 was admitted	I to the facility on 1/17/17, per			

STATE FORM

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		29890	B. WING		05/	24/2017
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ENEDIC	CTINE LIVING CTR FI	RIDIEV	ORNE ROAD N (, MN 55432	NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21426	Continued From pa	age 15	21426			
	R247's admission Minimum Data Set (MDS). R247's immunization record revealed R247 was given the first step TST on 1/18/17, with 0 millimeters (mm) results, but did not indicate negative results.					
	R257's admission I record revealed R2	d to the facility on 1/27/17, per MDS. R257's immunization 257 was given the first step th negative results, but did not s.				
	R222's admission I record revealed R2	d to the facility on 12/22/16, per MDS. R222's immunization 222 was given the first step with 0 mm results, but did not esults.	r			
	R125's admission I record revealed R1	to the facility on 11/25/16, per MDS. R125's immunization 25 was given the first step vith negative results, but did sults.				
	R315's admission I record revealed R3 TST on 1/11/17, wi R315 was given the	d to the facility on 1/11/17, per MDS. R315's immunization B15 was given the first step th 0 mm and negative results. e second step TST on 2/1/17, ts, but did not indicate mm				
	record revealed E3 on 3/10/17, with 0 r	3/21/17. E3's immunization was given the first step TST mm and negative results. The iven 5/23/17, but did not S.				
		on 5/24/17, the Director of ated they were not aware				

TATEMENT OF DEFIC			ER/SUPPLIER/CLIA CATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		29890)	B. WING		05/	24/2017
AME OF PROVIDER (R SUPPLIER		STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
ENEDICTINE LIV	ING CTR FR	IDLEY		ORNE ROAD , MN 55432	NORTHEAST		
PREFIX (EAC		MUST BE PRI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
tubercul have bo readings staff goi required be enter DON sta record b The faci dated 12 Employe of three symptor history, a infection administ single IC for TB 3 compon of active and c) T Mycobas either a address negative SUGGE director review/re Tubercu ensure t	th 0 millimet s. The DON ng forward the and the heat ing special i atted her exp oth 0 mm and heat ing special i atted her exp oth 0 mm and 2/14 indicate bes: 2. Bas components and c) Testir with Mycob tering either GRA 2. All . Baseline T ents: a) Ass TB disease esting for the cterium tube two-step TS the need for a results. STED METH of nursing o evise policie losis screen he policy wa ERIOD FOR	ng (TST) te er (mm) au stated she hat both re alth unit co nstructions ectation wa nd negative vention an ed: "PROCI seline TB s s: a) Asses TB disease ng for the p acterium t a two-step new Gues B screenin essing for e, b) Asses e presence erculosis by T or single r recording HOD OF C r designee s on reside ing and pe as being fo	had instructed adings were ordinators would to enter both. The as staff read and e going forward. d Screening policy EDURE for creening consists sing for current e, b) Assessing TB resence of uberculosis by baseline TST or ts will be screened g consists of three current symptoms sing TB history, e of infection with administering IGRA." It did not both 0 mm and ORRECTION: The , could ent and employee rform audits to				
(21) day	S.						

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		29890	B. WING		05/2	24/2017
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
BENEDI	CTINE LIVING CTR F		ORNE ROAD N 7, MN 55432	NORTHEAST		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	CORRECTION		
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21530	Continued From pa	ige 17	21530			
	reviewed at least m currently licensed b This review must be Appendix N of the S Surveyor Procedure Requirements in Lo the Department of I Health Care Finand This standard is in available through th system. It is not su B. The pharma irregularities to the and the attending p must be acted upor physician visit, or su pharmacist. For pu upon" means the au report and the signi of nursing services C. If the attend with the pharmacist not provide adequa pharmacist believes being adversely affir refer the matter to to if the medical direct physician lf the me the attending physic justification for the physician does not must be referred fo assessment and as by part 4658.0070. the medical direct must refer the matter	en of each resident must be nonthly by a pharmacist by the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan ubject to frequent change. acist must report any director of nursing services shysician, and these reports n by the time of the next ooner, if indicated by the urposes of this part, "acted cceptance or rejection of the ing or initialing by the director and the attending physician. ling physician does not concur t's recommendation, or does the justification, and the s the resident's quality of life is ected, the pharmacist must the medical director for review tor is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter or review to the quality surance committee required If the attending physician is or, the consulting pharmacist er directly to the quality asurance committee.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		29890	B. WING		05/	05/24/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	ADDRESS, CITY, STATE, ZIP CODE				
BENEDI	CTINE LIVING CTR FI	RIDI FY	ORNE ROAL , MN 55432	NORTHEAST			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE	
21530	Continued From pa	age 18	21530				
	This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to complete monthly consultant pharmacist reviews and act upon pharmacy recommendations for 1 of 5 residents reviewed, R193. In addition, the facility failed to develop procedures which provided accurate responsibilities of the consultant pharmacist, the director of nursing (DON) and physician and medical director. This had the potential to impact all residents at the facility. Findings include: R193's entry tracking Minimum Data Set (MDS)			Acknowledged.			
	R193's progress no pharmacist reviewe 4/19/17, 4/29/17 ar pharmacist reviews	sion date of 2/24/17. otes revealed consultant ed R193's record on 3/31/17, nd 5/11/17. No consultant s were provided indicating s were reviewed within 30 days					
	three recommenda and 4/29/17. The 4 "This resident has I locate a diagnosis f resident's chart. We indications support inhibitor use or con discontinuation?" (famotidine, a medic the stomach and for stomach produces recommendation ne	t Recommendations revealed tions dated 4/3/17, 4/17/17 /3/17 recommendation noted been on Pepcid. I could not for this medication in the ould you please circle the ing continued proton pump sider tapering off or Pepcid is also called cation used to treat ulcers in or conditions where the too much acid.) The 4/17/17 oted "This 89 Y.O [year old] g (benzodiazepine): Diazepam					

		Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
BENEDIC	CTINE LIVING CTR FI	RIDLEY	BORNE ROAD I Y, MN 55432	NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 19	21530			
	falls***& hospitaliza included warnings i benzodiazepines in impairment, delirium motor vehicle accid guidance included, necessary, please risk vs. benefit." A a repeated recomm The recommendati physician. There w physician noted. R193's physician p signed by the R193 revealed current or 20 mg (milligrams) diazepam 2.5 mg te	ecent H/O [history of] of ation" The recommendation including "In general, all herease risk of cognitive m, falls***, fractures, and dents in older adults." The "If use of this medication is document an assessment of 4/29/17 recommendation was nendation related to Pepcid. ions were addressed to R193's as no response from the rogress notes, electronically 8's physician on 5/17/17, ders for famotidine (Pepcid) tablet twice daily and wice daily.				
	nurse practitioner p 4/10/17, 4/13/17, 4 and 5/17/17 reveal	progress notes, dated 4/3/17, /21/17, 4/24/17, 5/2/17, 5/9/17 ed no indication the consultant nendations were reviewed or	,			
	(DON) reviewed the follow up to consult recommendations, 4/29/17. DON repo physician to review	dated 4/3/17, 4/17/17 and rted she would expect the consultant pharmacist and address whether or not a				
	(RN)-B reported sh	a.m., the nurse manager ne could not find any follow up onsultant pharmacist				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		29890	B. WING		05/	24/2017
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
BENEDIC	TINE LIVING CTR F	RIDI FY	ORNE ROAD I (, MN 55432	NORTHEAST		
(X4) ID	SUMMARY STA		I, WIN 33432	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET
21530	Continued From pa	age 20	21530			
	pharmacist reporte marked as urgent, pharmacist recomm the next physician of within 30 days. The Pharmacy Rec dated 12/14, director review on each gue monthly by a licens pharmacist will report Director of Nursing designee will conta pharmacist's time r "immediately", "with reports will be acted (2)-The Director of are not required to "acceptance" or "re must, however, act be accomplished in indicating acceptant and signing their na response is docum recommendation re pharmacy book loc office. 5. Any report upon by the physici Medical Director fo Director will report Assurance Commit the attending physi the Medical Director SUGGESTED MET	hin 60 days", etc. 3. These d upon Per statute 483.60(c) Nursing or attending physiciar provide a rationale for their ejection" of the report. They upon the request. This may many ways, such as nee or rejection of the report ames. 4. The physician's ented on the pharmacy eport form, and placed in the ated in the Director of Nursing ts/recommendations not acted ian will be directed to the r review. 6. The Medical findings to the Quality ttee. Any further follow-up with cian will be the responsibility of or or the Director of Nursing signee."	f			
	administrator, direc	tor of nursing (DON) and cist could review and revise				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		29890	B. WING		05/	24/2017
AME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
ENEDI	CTINE LIVING CTR FI		ORNE ROAD N (, MN 55432	NORTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 21	21530			
	consultant pharmae staff, the medical d physicians and phy educated as neces acting upon the pha designee, along wit medication reviews compliance.	dures for following up on cist recommendations. Nursing irector and attending visician extenders could be sary to the importance of the armacist's review. The DON or th the pharmacist, could audit a on a regular basis to ensure R CORRECTION: Twenty-one				