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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 93VD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 29890

1. MEDICARE/MEDICAID PROVIDER NO.
(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** (L6) **55432**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/15/2017** (L34)

8. ACCREDITATION STATUS: 10/23/2017 (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

Mandatory DOPNA, effective 08/24/2017, is discontinued effective 07/14/2017

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor — 08/15/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 09/07/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/18/2015
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00000
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/03/2017
(L33)

DETERMINATION APPROVAL

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.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On, October 23, 2017

I, Nicole Donahue, Administrator, 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: Nicole Donahue, Administrator, 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 II RN, 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 NICOLE DONAHUE,
(Name)(Please Print)
ADMINISTRATOR, Date 10/23/2017
(Title)(Please Print)

Signed: MOMODOU L. FATTY (MLFatty), NURSE EVALUATOR II ~~ADMINISTRATOR~~ RN, Date 10/23/2017
(Name)(Please Print) (Title)(Please Print)

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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Signed: _____, _____, Date _____
(Name)(Please Print) (Title)(Please Print)

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

The Notice of Penalty Assessment was handed to _____,
(Name)(Please Print)
_____, Date _____
(Title)(Please Print)

Signed: _____, _____, Date _____
(Name)(Please Print) (Title)(Please Print)

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

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7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

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(L9)

6. DATE OF SURVEY **08/15/2017** (L34)

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

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02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

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To (b) :

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

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
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Susanne Reuss, Unit Supervisor 08/15/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 09/07/2017 (L20)

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03/18/2015
(L24)

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25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

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(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/03/2017
(L33)

DETERMINATION APPROVAL

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 Christine.Vause@cms.hhs.gov. 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 all 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 https://dab.efile.hhs.gov/. 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 https://dab.efile.hhs.gov/user_sessions/new 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**.

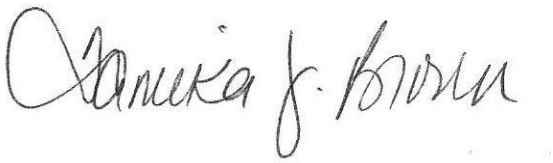
Please note that **all** hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. 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 no later than 60 days 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,



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

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.

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,

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

DEPARTMENT OF HEALTH

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

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,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On ,

I, _____, _____, 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: _____, _____, Date _____
(Name)(Please Print) (Title)(Please Print)

DELIVERY OF LICENSING PENALTY ASSESSMENT NOTICE

On ,

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 _____,
(Name)(Please Print)
_____, Date _____
(Title)(Please Print)

Signed: _____, _____, Date _____
(Name)(Please Print) (Title)(Please Print)

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 93VD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 29890

1. MEDICARE/MEDICAID PROVIDER NO.
(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** (L6) **55432**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/24/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Mary Heim, HFE NE II — 06/21/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 07/03/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/18/2015
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00000
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 07/03/2017 Co.

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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:

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

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

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

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

Informal Dispute Resolution - 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

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

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

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

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

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

Feel free to contact me if you have 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

MDH
Minnesota
Department
of Health

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:

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

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months after the survey date; and

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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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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 [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:

- 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));

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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

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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 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:

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

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

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

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

Mr. 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

Feel free to contact me if you have 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245623	A. BUILDING _____ B. WING _____	05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CTR FRIDLEY	**520 OSBORNE ROAD NORTHEAST FRIDLEY, MN 55432**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/21/17, 5/22/17, 5/23/17 and 5/24/17 a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for	F 279		7/3/17

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

Electronically Signed | 06/16/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245623	A. BUILDING _____ B. WING _____	05/24/2017

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F 279	Continued From page 1 each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 279		

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F 279	Continued From page 2 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a care plan for assessed nutritional risk for 2 of 3 residents (R315 and R129) reviewed for nutrition. Findings include: The facility failed to develop a comprehensive nutrition care plan for R315. R315's care area assessment, dated 1/17/17, revealed R315 was on dialysis and was at risk for poor diet compliance. 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. Review of the care plan, updated 5/12/17, revealed no problems, goals related to nutrition services. There was no indication how often a qualified dietitian would review R315's status or how coordination related to R315's nutrition status would occur between the facility and	F 279	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 waiving the foregoing statement, the facility states: 1) With respect to R315; a comprehensive nutrition care plan has been developed based on the nutritional assessment with input from R315 which includes: frequency of Registered Dietician review, coordination between facility and dialysis center; and Guest's non-compliance. 2) With respect to R129; a comprehensive care plan has been developed based on Guest's Nutritional assessment with input from R129 which includes interventions to prevent unintentional weight loss and maintain fluid balance. 3) All Guests have the potential to be affected. 4) The facility care plan policy and procedures were reviewed. The	

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F 279	Continued From page 3 dialysis center. R315's care plan noted R315 was non compliant with fluid restrictions. No individualized interventions were noted to address compliance. R315's level of compliance with diet recommendations and supplements were not addressed. R315's discharge plan of care, dated 2/11/17, revealed instructions related to diet order, precautions and indicated R315 had no supplements. A dialysis center IDT [interdisciplinary] patient POC [plan of care] Meeting Report, dated 8/29/16 (prior to R315's admission to the facility), was reviewed. No interventions specific to how the skilled nursing facility should care for R315 were noted. R315 was noted to be "Stable" A review of an updated IDT Patient POC Meeting report, dated 5/15/17 and faxed on 3/23/17 (after R315's 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.	F 279	Registered Dietician will be responsible for ensuring each Guest has a nutritional assessment and care plan in place per policy. 5) The Director of Clinical Nutrition and/or designee will audit three Guests per week for one month and then two Guests per week for two months to ensure compliance with our care plan policy. 6) The data collected from the audits will be presented to the facility Quality Council (QC) by the Director of Clinical Nutrition and/or designee and discussed during monthly QC meetings for three months. The QC will make the decision/recommendation regarding any necessary follow-up studies. 7) Corrective action will be completed by July 3, 2017.	

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F 279	Continued From page 4 On 5/22/17 at 6:43 p.m., the nursing manager, (RN)-B, reported the only nutrition care plan she could find was the discharge care plan. RN-B reported the dialysis center also had their own nutrition care plan. RN-B pointed out the dialysis patient plan of care. On 5/23/17 at 10:23 a.m., the dialysis center dietician, (RD)-B, reported R315 had issues with non-compliance with diet, fluid restrictions and taking the Velphoro. During an observation on 5/23/17 at 8:49 a.m., observed R129 eating breakfast independently in R129's room while sitting in wheelchair next to the bed. R129 ate breakfast without difficulty in chewing and or swallowing the food and drinks. R129's Nutrition Care Area Assessment (CAA) 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.	F 279		

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F 279	Continued From page 5 On 5/23/17 at 1:01p.m., the registered nurse (RN)-C verified that R129's medical record including care plan lacked nutritional status and dehydration/fluid maintenance even though the admission MDS triggered the CAAs. RN-C verified R129 experienced a weight loss. RN-C stated, the expectation was a nutritional status and dehydration/fluid maintenance care plan should be in place. On 5/23/17 at 1:12 p.m., RN-D verified that care plan lacked nutritional status and dehydration/fluid maintenance and stated dietician was supposed to do the care plan for nutritional status and dehydration/fluid maintenance. Policy and procedure titled CARE PLAN POLICY AND PROCEDURE dated 04/17, directed staff, "1. Each department will gather needed information on admission to provide data for the 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."	F 279		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 325		7/3/17

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F 325	Continued From page 6 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nutrition services were provided to meet the needs for 2 of 3 residents (R315 and R129) reviewed for nutrition. Findings include: The facility failed to ensure adequate nutrition services provided for R315. R315's care area assessment, dated 1/17/17, revealed [R315's] wt [weight] increased 0.8# from [R315's] wt of 189.6# on 1/4/17. [R315] has had large wt changes d/t edema, following: sepsis, osteomyelitis, let ankle amputation, dialysis, and IV fluids. Wt changes are expected between dialysis tx [treatment]. [R315's] wts ranged between 184-198# since admit and between 172-190# at the hospital. [R315] receives a renal, diabetic diet with snacks offered between meals. Dialysis added a 1500 ml [milliliter] FR [fluid	F 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 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 waiving the foregoing statement, the facility states: 1) With respect to R315; a comprehensive nutrition care plan has been developed based on the nutritional assessment with input from R315 which includes: frequency of Registered Dietician review, coordination between facility and dialysis center; and Guest's non-compliance. Nurses will administer Velphoro as ordered. Guests refusals will be documented and Velphoro will not be left	

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F 325	Continued From page 7 restriction] on 1/19/17. Culinary provides 750 ml and nursing provides 750 ml/day. [R315] is able to feed [R315] with tray set-up at meals. At risk for poor diet tolerance as would be e/b [evidenced by]: choking, wt loss, PCM [protein calorie malnutrition], anorexia, abnormal labs, constipation, skin breakdown, and dehydration. Dehydration can cause: electrolyte imbalance, poor skin turgor, increased risk of skin breakdown, constipation, weakness's, and weight fluctuations. Maintain current level of functioning." There was no indication the dietician completing the assessment met with R315 for input. The section for "input from resident and/or family/representative regarding the care area" was left blank. 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. Review of the care plan, updated 5/12/17, revealed no problems, goals related to nutrition services. There was no indication how often a qualified dietitian would review R315's status or how coordination related to R315's nutrition status would occur between the facility and dialysis center. R315's care plan noted R315 was non compliant with fluid restrictions. No individualized interventions were noted to address compliance. R315's level of compliance with diet	F 325	in room. 2) With respect to R129; a comprehensive care plan has been developed based on Guest's nutritional assessment with input from R129 which includes interventions to prevent unintentional weight loss and maintain fluid balance. 3) All Guests have the potential to be affected. 4) The facility care plan policy and procedures were reviewed and revised for implementation. The Registered Dietician will be responsible for ensuring each Guest has a nutritional assessment and care plan per policy based on input from Guests that includes individual nutritional needs, special diets and non-compliance. 5) Nurses will receive re-education on facility guidelines for medication administration. 6) The Director of Clinical Nutrition and/or designee will audit three Guest's medical records per week for one month and then two Guest's medical records per week for two months to ensure compliance. 7) The data collected from the audits will be presented to the facility Quality Council (QC) by the Director of Clinical Nutrition and/or designate and discussed during monthly QC meetings fro three months. The QC will make the decision/recommendation regarding any necessary follow-up studies.	

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F 325	Continued From page 8 recommendations and supplements were not addressed. R315's discharge plan of care, dated 2/11/17, revealed instructions related to diet order, precautions and indicated R315 had no supplements. A dialyisis center IDT [interdisciplinary] patient POC [plan of care] Meeting Report, dated 8/29/16 (prior to R315's admission to the facility), was reviewed. No interventions specific to how the skilled nursing facility should care for R315 were noted. R315 was noted to be "Stable" A review of an updated IDT Patient POC Meeting report, dated 5/15/17 and faxed on 3/23/17 (after R315's 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. Review of R315's progress notes for January to May 2017, revealed 2 nutrition follow up notes by a qualified dietician. One was written on 5/22/17 at 7:33 p.m. The other was written on 5/23/17 and noted as a late entry for 5/18/17. R315's Weekly Rounding Sheet from the dialysis center, dated 5/23/17 revealed the recent following abnormal lab results: high blood urea nitrogen, high potassium, high phosphorous and low hemoglobin. Weight changes between pre and post treatment for 5/12/17 to 5/22/17 revealed weight changes between -2.0 kg [kilograms] and 12.8 kg, or -2.2% to 12.8%. On 5/22/17 at 6:21 p.m., the facility dietician (RD)-A, revealed RD-A had started at the facility	F 325	8) Corrective action will be completed by July 3, 2017.	

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F 325	Continued From page 9	F 325		

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.

On 5/22/17 at 5:38 p.m., the registered nurse on R315's floor noted R315 had concerns with compliance related to diet and fluid restrictions.

On 5/22/17 at 5:50 p.m., R315's nursing assistant, (NA)-A, revealed R315 had issues with non-compliance related to diet and fluid restrictions.

On 5/22/17 at 6:42 p.m., the dietary aide (DA)-A, reported residents were allowed to order what they wanted. R315 was not always compliant with ordered diet.

On 5/22/17 at 6:43 p.m., the nursing manager, (RN)-B, reported the only nutrition care plan she could find was the discharge care plan. RN-B reported the dialysis 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 Velphoro with meals, R315 reported R315 almost forgot to take them until surveyor

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F 325	Continued From page 10 asked about them. R315 took 2 brown pills, yet more remained in a medication cup on the tray table. R315 had a cup of fruit, including cantaloupe on the breakfast tray. On 5/23/17 at 10:23 a.m., the dialysis center dietician, (RD)-B, reported R315 had issues with non-compliance with diet, fluid restrictions and taking the Velphoro. RD-B reported she had little communication with the dietician at the facility as she had difficulty connecting with one when she called. RD-B reported typically she would check in with the facility RD each month when working with other skilled nursing facilities. However, she was speaking with primarily only nursing to get updates from the facility for R315. During an observation on 5/23/17 at 8:49 a.m., observed R129 eating breakfast independently in R129's room while sitting in wheelchair next to the bed. R129 ate breakfast without difficulty in chewing and or swallowing the food and drinks. R129's physician orders dated 4/23/17, indicated, "... Continue Levaquin through 4/29 start Doxycycline 100 mg (milligram) po (by mouth) q (every) 12 hours continue Rifampin 300 mg po q 12 hours" Dated 5/1/17 reads, "Start Zofran 4 mg po BID (twice a day)" In addition, physician order dated 5/9/17, read, "Please update ID (infection disease): guest has loss of appetite since start Doxycycline would like alternate or f/u with provider ..." R129's admission minimum data set (MDS), dated 3/21/17, identified R129 was cognitively intact, independent after set up with eating, was on a therapeutic diet, and noted diagnosis of anemia, multidrug-resident organism, diabetes	F 325		

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F 325	Continued From page 11 mellitus, pneumonia and respiratory failure. R129's progress notes dated 5/11/17 at 3:54 p.m. read, "The Infectious Disease MD (medical doctor) called today, D/Ced (discontinued) the Vibramycin for the guest, and ordered Minocycline 100mg PO BID. Guest continues to C/O (complain of) nausea. Gave PRN (as needed) dose of Zofran at 1215 (12:15 p.m.) for C/O nausea and it was effective in decreasing the C/O nausea. Dressing to right L/E changed this AM (morning). Blistered area remains open. Serous drainage noted on dressing that was removed. Area cleansed and redressed as ordered." R129's Nutrition Care Area Assessment (CAA) 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 electronic medication administration record (EMAR) and electronic treatment administration record (eTAR) was reviewed for April and May 2017. The medical record lacked orders for nutritional supplement. R129's weight on 4/20/17 was 232 pounds. Weight on 5/18/17 was 209 pounds (which was 23 lbs. less than on the first date or a 11.0% loss).	F 325		

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F 325	Continued From page 12 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. On 5/23/17 at 9:01 a.m., R129 indicated that [R129] lost weight unintentional and did not prefer the way [R129] lost the amount of weight due to swell throat and antibiotic that [R129] was taking that made [R129] lose appetite. On 5/23/17 at 9:55 a.m., nursing assistant (NA)-B stated have not seen R129 eat much for a long time and does not know the reason but maybe R129 feels down and sad or depressed. On 5/23/17 at 10:39 a.m. registered nurse (RN)-G R129 started on Doxycycline and rifampin together by infection disease doctor and was experiencing nausea from it, which was then changed. On 5/23/17 at 10:55 a.m., registered dietician (RD) stated R129 admitted from the hospital and was having IV fluids that could also cause the weight gain, and then started losing weight. On 5/23/17 at 1:01p.m., RN-C verified that R129's medical record including care plan lacked nutritional status and dehydration/fluid maintenance even though the admission MDS triggers the CAAs and resident lost weight. RN-C stated, expectation was nutritional status and dehydration/fluid maintenance care plan should be in place.	F 325		

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F 325	Continued From page 13 On 5/23/17 at 1:12 p.m., RN-D verified that care plan lacked nutritional status and dehydration/fluid maintenance and stated dietician was supposed to do the care plan for nutritional status and dehydration/fluid maintenance.	F 325		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.	F 356		7/3/17

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F 356	Continued From page 14 (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the required nurse staffing information daily. This had the potential to affect all 49 residents residing in the facility and visitors. Findings include: During observation on 5/21/17, at 8:46 a.m. the posted Staffing Hours report for Nursing for public display was dated 5/17/17, with a census of 48. On 5/21/17, at 12:47 p.m. the 5/21/17, the staffing hours report was observed posted. During interview on 5/21/17, at 3:41 p.m. the administrator verified the daily staffing hours report had not been posted since 5/17/17, and was aware it was posted at the front concierge desk.	F 356	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 waiving the foregoing statement, the facility states: 1) With respect to posting Nurse Staffing Information; the actual hours worked were completed and posted on 5/21/2017. 2) The Staffing Coordinator received re-education regarding the requirement for posting the Nurse Staffing Information daily.	

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F 356	Continued From page 15 During interview on 5/23/17, at 1:26 p.m. the administrator stated the staffing coordinator (SC) was responsible for posting the staffing hours report at the beginning of the day. The administrator indicated the SC worked Monday through Friday, not weekends, had spoken to the SC, and was informed there was no process for posting staffing hours. The administrator further stated the SC will be posting them on Friday for the weekend and the weekend nurse supervisor would be responsible to post each daily staffing hours report and update them with any staffing changes. During interview on 5/24/17, at 9:13 a.m. SC stated she works Monday through Friday and posts the staffing hours report then. SC verified the postings should have been posted daily last week. SC further indicated the reports would now be posted daily on the display case board for Friday, Saturday, and Sunday, and indicated the weekend nurse supervisor would up-date them with any staffing changes. The undated facility's Posting of Staffing Hours policy indicated nursing staffing hours would be posted "in conformity with CMS requirements"... The Staffing Coordinator/Designee is responsible for completing the form on a daily basis... 2. Changes on the posted form will be made during the shift."	F 356	3) The facility policy for posting nurse staffing information has been reviewed and revised for implementation. 4) All associated staff will receive education on the facility policy for posting Nurse Staffing Information. 5) The Administrator and/or designee will audit the posting for accuracy and timeliness two times per week for three months to ensure compliance. 6) The data collected from the audits will be presented to the Quality Council (QC) by the Administrator and/or designee. The data will be reviewed/discussed during monthly QC meetings for three months. The QC will make the decision/recommendation regarding any necessary follow-up studies. 7) Corrective action will be completed by July 3, 2017.	
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed	F 428		7/3/17

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F 428	Continued From page 16 pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies	F 428		

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F 428	Continued From page 17 and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This 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 faciity 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) revealed an admission date of 2/24/17. R193's progress notes revealed consultant pharmacist reviewed R193's record on 3/31/17, 4/19/17, 4/29/17 and 5/11/17. No consultant pharmacist reviews were provided indicating R193's medications were reviewed within 30 days of admission. R193's Pharmacist Recommendations revealed three recommendations dated 4/3/17, 4/17/17 and 4/29/17. The 4/3/17 recommendation noted "This resident has been on Pepcid. I could not locate a diagnosis for this medication in the resident's chart. Would you please circle the indications supporting continued proton pump inhibitor use or consider tapering off or	F 428	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 waiving the foregoing statement, the facility states: 1) With respect to R193; an initial review was completed by the pharmacist on 3/31/2017. 2) All Guests have the potential to be affected. 3) The facility policy and procedures for following up on consultant pharmacist recommendations was reviewed and revised. 4) All staff associated with this process will receive re-education on addressing pharmacy reviews. 5) The Director of Nursing and/or designee will audit two Guests per week for one month and then one Guest per	

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F 428	Continued From page 18 discontinuation?" (Pepcid is also called famotidine, a medication used to treat ulcers in the stomach and for conditions where the stomach produces too much acid.) The 4/17/17 recommendation noted "This 89 Y.O [year old] resident is receiving (benzodiazepine): Diazepam BID [twice daily] Recent H/O [history of] of falls***& hospitalization" The recommendation included warnings including "In general, all benzodiazepines increase risk of cognitive impairment, delirium, falls***, fractures, and motor vehicle accidents in older adults." The guidance included, "If use of this medication is necessary, please document an assessment of risk vs. benefit." A 4/29/17 recommendation was a repeated recommendation related to Pepcid. The recommendations were addressed to R193's physician. There was no response from the physician noted. R193's physician progress notes, electronically signed by the R193's physician on 5/17/17, revealed current orders for famotidine (Pepcid) 20 mg (milligrams) tablet twice daily and diazepam 2.5 mg twice daily. Review of R193's record, including physician and nurse practitioner progress notes, dated 4/3/17, 4/10/17, 4/13/17, 4/21/17, 4/24/17, 5/2/17, 5/9/17, and 5/17/17 revealed no indication the consultant pharmacist recommendations were reviewed or acted upon. On 5/24/17 at 8:54 a.m., the director of nursing (DON) reviewed the chart with surveyor. No follow up to consultant pharmacist recommendations, dated 4/3/17, 4/17/17 and 4/29/17. DON reported she would expect the physician to review consultant pharmacist	F 428	week for two months to ensure compliance. 6) The data collected from the audits will be presented to the facility Quality Council (QC) by the Director of Nursing and/or designee and discussed during monthly QC meetings for three months. The QC will make the decision/recommendation regarding any necessary follow-up studies. 7) Corrective action will be completed by July 3, 2017.	

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F 428	Continued From page 19	F 428		

recommendations and address whether or not a change should be made.

On 5/24/17 at 9:00 a.m., the nurse manager (RN)-B reported she could not find any follow up to the April 2017 consultant pharmacist recommendations.

On 5/24/17 at 11:37 a.m. the consultant pharmacist reported, unless concerns were marked as urgent, he would expect consultant pharmacist recommendations to be acted upon at the next physician or nurse practitioner visit or within 30 days.

The Pharmacy Recommendations procedure, dated 12/14, directed staff "1. A drug regimen review on each guest will be performed at least monthly by a licensed pharmacist. 2. The pharmacist will report any irregularities to the Director of Nursing Services. The DON and/or designee will contact the physician per the pharmacist's time requirements, i.e., "immediately", "within 60 days", etc. 3. These reports will be acted upon Per statute 483.60(c) (2)-The Director of Nursing or attending physician are not required to provide a rationale for their "acceptance" or "rejection" of the report. They must, however, act upon the request. This may be accomplished in many ways, such as indicating acceptance or rejection of the report and signing their names. 4. The physician's response is documented on the pharmacy recommendation report form, and placed in the pharmacy book located in the Director of Nursing office. 5. Any reports/recommendations not acted upon by the physician will be directed to the Medical Director for review. 6. The Medical Director will report findings to the Quality

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F 428	Continued From page 20 Assurance Committee. Any further follow-up with the attending physician will be the responsibility of the Medical Director or the Director of Nursing Services and/or designee."	F 428		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431		7/3/17

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F 431	Continued From page 21 instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were dated when opened for 1 of 7 residents (R321) on 1 of 4 units (Rhapsody Boulevard) and failed to ensure 29 of 65 occlusive adaptive gauze were removed from the stock supply in 1 of 2 medication storage rooms after having expired. This had the potential to affect 0 residents prescribed an occlusive adaptive guaze and any of the 49 residents currently residing at the facility if a physician ordered the occlusive adaptive gauze for any of the residents; or if a resident was admitted to the facility with an order for the occlusive adaptive gauze. Findings include: On 5/21/17, at 8:38 a.m. the medication cart for	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 waiving 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 affected.	

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F 431	Continued From page 22 Rhapsody Boulevard was reviewed. In the cart, 1 of 7 insulin pens or vials were not dated when opened. Licensed practical nurse (LPN)-A verified at this time the Novolin N insulin pen was for R321 and was not dated when opened. A review of the medical record revealed R321 was admitted on 5/9/17, and physician orders indicated R321 was receiving 37 units of Novolin N in the morning and 32 units in the evening. On 5/24/17, at 7:30 a.m. 29 of 65 stock supply Xeroform Occlusive Gauze strips were noted to have expired on 3/17. At 8:00 a.m. the expiration date of the Xeroform was verified with registered nurse (RN)-B. On 5/24/17, at 10:00 a.m. the director of nurses (DON) stated someone from the consulting pharmacy had been in the facility 1-2 weeks prior and had not mentioned anything about the Xeroform strips having been expired 3/17 or that insulin was not dated when opened. The DON provided a Med Room Inspection form dated 5/17/17, and the forms indicated expired items in medication storage room cabinets and refrigerator had been removed for destruction or return. The expired Xeroform was not addressed on the form. On 5/24/17, at 10:35 a.m. the consulting pharmacist stated he would check with the registered nurse who had conducted the med room inspection to determine if she would have considered the Xeroform a medication, and part of the review. Or if checking the Xeroform for expiration was something the nursing department at the facility should be checking on.	F 431	3) Facility will review and revise policy and procedures for medication labeling and storage. 4) All staff associated with this will receive re-education regarding the policy and procedures for medication/biologics labeling and storage. 5) The Director of Nursing and/or designee will complete an audit on all Guests who currently use insulin pens and random audits thereafter; two med carts and one med room will be audited per week for one month and then one med cart and one med room will be audited per week for two months to ensure compliance. 6) The data collected from these audits will be presented to the facility Quality Council (QC) by the Director of Nursing and/or designee and discussed monthly during QC meetings for three months. The QC committee will make the decision/recommendation regarding any necessary follow-up studies. 7) Corrective action will be completed by July 3, 2017.	

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F 431	Continued From page 23 At 11:38 a.m. the consulting pharmacist called the surveyor and stated he placed a call to the registered nurse who did the med room inspection and left a message. He is thinking that if the Xeroform is not a medication then it would be a nursing and not a pharmacy requirement to review for expiration. On 5/24/17, between 10:45 to 11:00 a.m. RN-B, RN-C, RN-E stated they currently did not have any resident who was using the Xeroform gauze. On 5/24/17, at 1:05 p.m. the DON stated a nurse would check the Xeroform packaging for the expiration date before using the product. The DON stated here was no policy regarding nursing staff checking treatment products for expiration dates. The DON also stated she had checked with RN-B, RN-C and RN-E as to whether or not any resident had used the Xeroform between 4/1 and 5/24/17. The DON stated RN-B, RN-C and RN-E told her no residents during that time period received the Xeroform. The facility's 10/22/13, policy titled Medication Storage in the Facility provided by the DON did not address the dating when opened medications. By the time of the exit on 5/24/17, the pharmacist had not called back regarding if the nurse who conducted the med room inspection would or would not have looked at the Xeroform.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245623	A. BUILDING **01 - BENEDICTINE LIVING CENTER FRIDLEY** B. WING _____	**05/24/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CTR FRIDLEY	**520 OSBORNE ROAD NORTHEAST FRIDLEY, MN 55432**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Interlude Restorative Suites of Fridley was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Interlude Restorative Suites of Fridley is a 3-story building without a basement. The building was constructed in 2014 and was determined to be of Type II(111) construction. The building is has a full fire sprinkler system and a fire alarm system with smoke detection in the corridors, by the smoke barrier doors, resident rooms and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 50 beds and had a census of 48 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

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

MDH
Minnesota
Department
of Health

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29890	A. BUILDING: _____ B. WING _____	05/24/2017

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BENEDICTINE LIVING CTR FRIDLEY	520 OSBORNE ROAD NORTHEAST FRIDLEY, MN 55432

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On dates, 5/21/17, 5/22/17, 5/23/17 and 5/24/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a care plan for assessed nutritional risk for 2 of 3 residents (R315 and R129) reviewed for nutrition. Findings include: The facility failed to develop a comprehensive nutrition care plan for R315. R315's care area assessment, dated 1/17/17, revealed R315 was on dialysis and was at risk for	2 555	Acknowledged.	7/3/17

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2 555	Continued From page 3 poor diet compliance. 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. Review of the care plan, updated 5/12/17, revealed no problems, goals related to nutrition services. There was no indication how often a qualified dietitian would review R315's status or how coordination related to R315's nutrition status would occur between the facility and dialysis center. R315's care plan noted R315 was non compliant with fluid restrictions. No individualized interventions were noted to address compliance. R315's level of compliance with diet recommendations and supplements were not addressed. R315's discharge plan of care, dated 2/11/17, revealed instructions related to diet order, precautions and indicated R315 had no supplements. A dialysis center IDT [interdisciplinary] patient POC [plan of care] Meeting Report, dated 8/29/16 (prior to R315's admission to the facility), was reviewed. No interventions specific to how the skilled nursing facility should care for R315 were noted. R315 was noted to be "Stable" A review of an updated IDT Patient POC Meeting report, dated 5/15/17 and faxed on 3/23/17 (after R315's	2 555		

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2 555	Continued From page 4 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. On 5/22/17 at 6:43 p.m., the nursing manager, (RN)-B, reported the only nutrition care plan she could find was the discharge care plan. RN-B reported the dialysis center also had their own nutrition care plan. RN-B pointed out the dialysis patient plan of care. On 5/23/17 at 10:23 a.m., the dialysis center dietician, (RD)-B, reported R315 had issues with non-compliance with diet, fluid restrictions and taking the Velphoro. During an observation on 5/23/17 at 8:49 a.m., observed R129 eating breakfast independently in R129's room while sitting in wheelchair next to the bed. R129 ate breakfast without difficulty in chewing and or swallowing the food and drinks. R129's Nutrition Care Area Assessment (CAA)	2 555		

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2 555	Continued From page 5 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. On 5/23/17 at 1:01p.m., the registered nurse (RN)-C verified that R129's medical record including care plan lacked nutritional status and dehydration/fluid maintenance even though the admission MDS triggered the CAAs. RN-C verified R129 experienced a weight loss. RN-C stated, the expectation was a nutritional status and dehydration/fluid maintenance care plan should be in place. On 5/23/17 at 1:12 p.m., RN-D verified that care plan lacked nutritional status and dehydration/fluid maintenance and stated dietician was supposed to do the care plan for nutritional status and dehydration/fluid maintenance. Policy and procedure titled CARE PLAN POLICY AND PROCEDURE dated 04/17, directed staff, "1. Each department will gather needed information on admission to provide data for the	2 555		

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2 555	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.	2 555		
2 965	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 served.	2 965		7/3/17

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2 965	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nutrition services were provided to meet the needs for 2 of 3 residents (R315 and R129) reviewed for nutrition. Findings include: The facility failed to ensure adequate nutrition services provided for R315. R315's care area assessment, dated 1/17/17, revealed [R315's] wt [weight] increased 0.8# from [R315's] wt of 189.6# on 1/4/17. [R315] has had large wt changes d/t edema, following: sepsis, osteomyelitis, let ankle amputation, dialysis, and IV fluids. Wt changes are expected between dialysis tx [treatment]. [R315's] wts ranged between 184-198# since admit and between 172-190# at the hospital. [R315] receives a renal, diabetic diet with snacks offered between meals. Dialysis added a 1500 ml [milliliter] FR [fluid restriction] on 1/19/17. Culinary provides 750 ml and nursing provides 750 ml/day. [R315] is able to feed [R315] with tray set-up at meals. At risk for poor diet tolerance as would be e/b [evidenced by]: choking, wt loss, PCM [protein calorie malnutrition], anorexia, abnormal labs, constipation, skin breakdown, and dehydration. Dehydration can cause: electrolyte imbalance, poor skin turgor, increased risk of skin breakdown, constipation, weakness's, and weight fluctuations. Maintain current level of functioning." There was no indication the dietician completing the assessment met with R315 for input. The section for "input from resident and/or family/representative regarding the care area" was left blank.	2 965	Acknowledged.	

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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. Review of the care plan, updated 5/12/17, revealed no problems, goals related to nutrition services. There was no indication how often a qualified dietitian would review R315's status or how coordination related to R315's nutrition status would occur between the facility and dialysis center. R315's care plan noted R315 was non compliant with fluid restrictions. No individualized interventions were noted to address compliance. R315's level of compliance with diet recommendations and supplements were not addressed. R315's discharge plan of care, dated 2/11/17, revealed instructions related to diet order, precautions and indicated R315 had no supplements. A dialyisis center IDT [interdisciplinary] patient POC [plan of care] Meeting Report, dated 8/29/16 (prior to R315's admission to the facility), was reviewed. No interventions specific to how the skilled nursing facility should care for R315 were noted. R315 was noted to be "Stable" A review of an updated IDT Patient POC Meeting report, dated 5/15/17 and faxed on 3/23/17 (after R315's admission to facility) revealed R315 was	2 965		

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2 965	Continued From page 9 "unstable." Concerns were noted with elevated potassium levels and compliance with renal diet, supplement consumption, fluid management and taking Velphoro with meals. Review of R315's progress notes for January to May 2017, revealed 2 nutrition follow up notes by a qualified dietician. One was written on 5/22/17 at 7:33 p.m. The other was written on 5/23/17 and noted as a late entry for 5/18/17. R315's Weekly Rounding Sheet from the dialysis center, dated 5/23/17 revealed the recent following abnormal lab results: high blood urea nitrogen, high potassium, high phosphorous and low hemoglobin. Weight changes between pre and post treatment for 5/12/17 to 5/22/17 revealed weight changes between -2.0 kg [kilograms] and 12.8 kg, or -2.2% to 12.8%. 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. On 5/22/17 at 5:38 p.m., the registered nurse on R315's floor noted R315 had concerns with compliance related to diet and fluid restrictions. On 5/22/17 at 5:50 p.m., R315's nursing assistant, (NA)-A, revealed R315 had issues with non-compliance related to diet and fluid	2 965		

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2 965	Continued From page 10 restrictions. On 5/22/17 at 6:42 p.m., the dietary aide (DA)-A, reported residents were allowed to order what they wanted. R315 was not always compliant with ordered diet. On 5/22/17 at 6:43 p.m., the nursing manager, (RN)-B, reported the only nutrition care plan she could find was the discharge care plan. RN-B reported the dialysis 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 Velphoro with meals, R315 reported R315 almost forgot to take them until surveyor asked about them. R315 took 2 brown pills, yet more remained in a medication cup on the tray table. R315 had a cup of fruit, including cantaloupe on the breakfast tray. On 5/23/17 at 10:23 a.m., the dialysis center dietician, (RD)-B, reported R315 had issues with non-compliance with diet, fluid restrictions and taking the Velphoro. RD-B reported she had little communication with the dietician at the facility as she had difficulty connecting with one when she called. RD-B reported typically she would check in with the facility RD each month when working with other skilled nursing facilities. However, she was speaking with primarily only nursing to get updates from the facility for R315. During an observation on 5/23/17 at 8:49 a.m.,	2 965		

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2 965	Continued From page 11 observed R129 eating breakfast independently in R129's room while sitting in wheelchair next to the bed. R129 ate breakfast without difficulty in chewing and or swallowing the food and drinks. R129's physician orders dated 4/23/17, indicated, "... Continue Levaquin through 4/29 start Doxycycline 100 mg (milligram) po (by mouth) q (every) 12 hours continue Rifampin 300 mg po q 12 hours" Dated 5/1/17 reads, "Start Zofran 4 mg po BID (twice a day)" In addition, physician order dated 5/9/17, read, "Please update ID (infection disease): guest has loss of appetite since start Doxycycline would like alternate or f/u with provider ..." R129's admission minimum data set (MDS), dated 3/21/17, identified R129 was cognitively intact, independent after set up with eating, was on a therapeutic diet, and noted diagnosis of anemia, multidrug-resident organism, diabetes mellitus, pneumonia and respiratory failure. R129's progress notes dated 5/11/17 at 3:54 p.m. read, "The Infectious Disease MD (medical doctor) called today, D/Ced (discontinued) the Vibramycin for the guest, and ordered Minocycline 100mg PO BID. Guest continues to C/O (complain of) nausea. Gave PRN (as needed) dose of Zofran at 1215 (12:15 p.m.) for C/O nausea and it was effective in decreasing the C/O nausea. Dressing to right L/E changed this AM (morning). Blistered area remains open. Serous drainage noted on dressing that was removed. Area cleansed and redressed as ordered." R129's Nutrition Care Area Assessment (CAA) dated 3/24/17, identified R129 was at nutritional risk and read, " ... At risk for poor diet tolerance	2 965		

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2 965	Continued From page 12 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 electronic medication administration record (EMAR) and electronic treatment administration record (eTAR) was reviewed for April and May 2017. The medical record lacked orders for nutritional supplement. R129's weight on 4/20/17 was 232 pounds. Weight on 5/18/17 was 209 pounds (which was 23 lbs. less than on the first date or a 11.0% loss). 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. On 5/23/17 at 9:01 a.m., R129 indicated that [R129] lost weight unintentional and did not prefer the way [R129] lost the amount of weight due to swell throat and antibiotic that [R129] was taking that made [R129] lose appetite. On 5/23/17 at 9:55 a.m., nursing assistant (NA)-B stated have not seen R129 eat much for a long time and does not know the reason but maybe R129 feels down and sad or depressed. On 5/23/17 at 10:39 a.m. registered nurse	2 965		

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2 965	Continued From page 13 (RN)-G R129 started on Doxycycline and rifampin together by infection disease doctor and was experiencing nausea from it, which was then changed. On 5/23/17 at 10:55 a.m., registered dietician (RD) stated R129 admitted from the hospital and was having IV fluids that could also cause the weight gain, and then started losing weight. On 5/23/17 at 1:01p.m., RN-C verified that R129's medical record including care plan lacked nutritional status and dehydration/fluid maintenance even though the admission MDS triggers the CAAs and resident lost weight. RN-C stated, expectation was nutritional status and dehydration/fluid maintenance care plan should be in place. On 5/23/17 at 1:12 p.m., RN-D verified that care plan lacked nutritional status and dehydration/fluid maintenance and stated dietician was supposed to do the care plan for nutritional status and dehydration/fluid maintenance. SUGGESTED METHOD OF CORRECTION:The registered dietitian or designee could develop policies and procedures related to ensuring residents receive needed nutrition services. The registered dietitian or designee could educate staff regarding these polices, and audit resident records for compliance to these policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		

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21426	Continued From page 14	21426		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to document complete results of the tuberculosis (TB) skin (TST) that was given for 5 of 5 residents (R217, R257, R222, R125, R315) reviewed for TB screening. In addition, the facility failed to document complete results of the TST given for 1 of 5 employees (E3) reviewed for TB screening. Findings include: R247 was admitted to the facility on 1/17/17, per	21426	Acknowledged.	7/3/17

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21426	Continued From page 15 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 was admitted to the facility on 1/27/17, per R257's admission MDS. R257's immunization record revealed R257 was given the first step TST on 1/27/17, with negative results, but did not indicate mm results. R222 was admitted to the facility on 12/22/16, per R222's admission MDS. R222's immunization record revealed R222 was given the first step TST on 12/22/16, with 0 mm results, but did not indicate negative results. R125 was admitted to the facility on 11/25/16, per R125's admission MDS. R125's immunization record revealed R125 was given the first step TST on 11/25/16, with negative results, but did not indicate mm results. R315 was admitted to the facility on 1/11/17, per R315's admission MDS. R315's immunization record revealed R315 was given the first step TST on 1/11/17, with 0 mm and negative results. R315 was given the second step TST on 2/1/17, with negative results, but did not indicate mm results. E3's start date was 3/21/17. E3's immunization record revealed E3 was given the first step TST on 3/10/17, with 0 mm and negative results. The second step was given 5/23/17, but did not indicate any results. During an interview on 5/24/17, the Director of Nursing (DON), stated they were not aware	21426		

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21426	Continued From page 16 tuberculin skin testing (TST) test results had to have both 0 millimeter (mm) and negative readings. The DON stated she had instructed staff going forward that both readings were required and the health unit coordinators would be entering special instructions to enter both. The DON stated her expectation was staff read and record both 0 mm and negative going forward. The facility's TB Prevention and Screening policy dated 12/14 indicated: "PROCEDURE for Employees:... 2. Baseline TB screening consists of three components: a) Assessing for current symptoms of active TB disease, b) Assessing TB history, and c) Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step baseline TST or single IGRA... 2. All new Guests will be screened for TB 3. Baseline TB screening consists of three components: a) Assessing for current symptoms of active TB disease, b) Assessing TB history, and c) Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA." It did not address the need for recording both 0 mm and negative results. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies on resident and employee Tuberculosis screening and perform audits to ensure the policy was being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review	21530		7/3/17

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21530	Continued From page 17 A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.	21530		

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21530	Continued From page 18 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 faciity 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) revealed an admission date of 2/24/17. R193's progress notes revealed consultant pharmacist reviewed R193's record on 3/31/17, 4/19/17, 4/29/17 and 5/11/17. No consultant pharmacist reviews were provided indicating R193's medications were reviewed within 30 days of admission. R193's Pharmacist Recommendations revealed three recommendations dated 4/3/17, 4/17/17 and 4/29/17. The 4/3/17 recommendation noted "This resident has been on Pepcid. I could not locate a diagnosis for this medication in the resident's chart. Would you please circle the indications supporting continued proton pump inhibitor use or consider tapering off or discontinuation?" (Pepcid is also called famotidine, a medication used to treat ulcers in the stomach and for conditions where the stomach produces too much acid.) The 4/17/17 recommendation noted "This 89 Y.O [year old] resident is receiving (benzodiazepine): Diazepam	21530	Acknowledged.	

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21530	Continued From page 19 BID [twice daily] Recent H/O [history of] of falls***& hospitalization" The recommendation included warnings including "In general, all benzodiazepines increase risk of cognitive impairment, delirium, falls***, fractures, and motor vehicle accidents in older adults." The guidance included, "If use of this medication is necessary, please document an assessment of risk vs. benefit." A 4/29/17 recommendation was a repeated recommendation related to Pepcid. The recommendations were addressed to R193's physician. There was no response from the physician noted. R193's physician progress notes, electronically signed by the R193's physician on 5/17/17, revealed current orders for famotidine (Pepcid) 20 mg (milligrams) tablet twice daily and diazepam 2.5 mg twice daily. Review of R193's record, including physician and nurse practitioner progress notes, dated 4/3/17, 4/10/17, 4/13/17, 4/21/17, 4/24/17, 5/2/17, 5/9/17, and 5/17/17 revealed no indication the consultant pharmacist recommendations were reviewed or acted upon. On 5/24/17 at 8:54 a.m., the director of nursing (DON) reviewed the chart with surveyor. No follow up to consultant pharmacist recommendations, dated 4/3/17, 4/17/17 and 4/29/17. DON reported she would expect the physician to review consultant pharmacist recommendations and address whether or not a change should be made. On 5/24/17 at 9:00 a.m., the nurse manager (RN)-B reported she could not find any follow up to the April 2017 consultant pharmacist recommendations.	21530		

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21530	Continued From page 20 On 5/24/17 at 11:37 a.m. the consultant pharmacist reported, unless concerns were marked as urgent, he would expect consultant pharmacist recommendations to be acted upon at the next physician or nurse practitioner visit or within 30 days. The Pharmacy Recommendations procedure, dated 12/14, directed staff "1. A drug regimen review on each guest will be performed at least monthly by a licensed pharmacist. 2. The pharmacist will report any irregularities to the Director of Nursing Services. The DON and/or designee will contact the physician per the pharmacist's time requirements, i.e., "immediately", "within 60 days", etc. 3. These reports will be acted upon Per statute 483.60(c)(2)-The Director of Nursing or attending physician are not required to provide a rationale for their "acceptance" or "rejection" of the report. They must, however, act upon the request. This may be accomplished in many ways, such as indicating acceptance or rejection of the report and signing their names. 4. The physician's response is documented on the pharmacy recommendation report form, and placed in the pharmacy book located in the Director of Nursing office. 5. Any reports/recommendations not acted upon by the physician will be directed to the Medical Director for review. 6. The Medical Director will report findings to the Quality Assurance Committee. Any further follow-up with the attending physician will be the responsibility of the Medical Director or the Director of Nursing Services and/or designee." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise	21530		

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21530	Continued From page 21 policies and procedures for following up on consultant pharmacist recommendations. Nursing staff, the medical director and attending physicians and physician extenders could be educated as necessary to the importance of the acting upon the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		