CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: C6FZ

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY	AGENCY	I	Facility ID: 00314
MEDICARE/MEDICAID PROVIDER N (L1) 245360 2.STATE VENDOR OR MEDICAID NO. (L2) 770057500	10.	3. NAME AND ADD (L3) BENEDICTI (L4) 100 GLEN O (L5) NEW LOND	NE LIVING CO OAKS DRIVE			ONDON (L6) 56273	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9) 02/01/2011	NERSHIP	7. PROVIDER/SUI	PPLIER CATEGORY	Y 09 ESRD	02 13 PTIP	(L7) 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other omplaint
6. DATE OF SURVEY 01/12 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	// 2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPI	CE	FISCAL YEAR ENDING	DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	52 (L18) 52 (L17)	B. Not in Com	nce With equirements	1	2. 3. 4.	Approved Waivers Of Th Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code A*	e Following Requirements: 6. Scope of Servi7. Medical Direc)8. Patient Room S9. Beds/Room (L12)	tor
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 52	19 SNF	ICF	IID		15. FACILIT	TY MEETS (1) or 1861 (j) (1):	(L15)	
(L37) (L38) 16. STATE SURVEY AGENCY REMARK	(L39) KS (IF APPLICABLE S	(L42) HOW LTC CANCELL	(L43) LATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE	SURVEY AGENCY AF	PPROVAL	Date:
Austin Fry, HF	E NE II		01/12/2016	(L19)	Kate	JohnsTon, Pi	rogram Specialis	01/15/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAI	OFFICE (OR SINGLE STAT	TE AGENCY	
19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Par			IPLIANCE WITH C HTS ACT:	CIVIL	21.		cial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA	A-1513)
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE OF PARTICIPATION 11/01/1986	23. LTC AGREEMI BEGINNING		24. LTC AGREEME ENDING DATI		VOLUNTA 01-Merger,		0 INVOLUNT 05-Fail to M	L30) CARY eet Health/Safety eet Agreement
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATIVI A. Suspension of		(L25) (L44)		03-Risk of I	nvoluntary Termination eason for Withdrawal	OTHER	Status Change
(L27)	B. Rescind Sus	pension Date:	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMAI	RKS		
		03001						
	(L28)			(L31)	-			
31. RO RECEIPT OF CMS-1539	32	DETERMINATION (OF APPROVAL DA	ГЕ	Posted	02/12/2016 Co.		
	(L32)	12/02/2015		(L33)	DETERM	MINATION APPRO	OVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245360 January 15, 2016

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

Dear Mr. Ingersoll:

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

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

Effective January 4, 2016 the above facility is certified for or recommended for:

52 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Benedictine Living Community Of New London January 15, 2016 Page 2

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered January 15, 2016

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

RE: Project Number S5360027

Dear Mr. Ingersoll:

On December 28, 2015, we informed you that the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 20, 2016. (42 CFR 488.417 (b))

Also, we notified you in our letter of December 28, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 20, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on October 20, 2015, that included an investigation of complaint number H5360015, and lack of verification of substantial compliance with the health deficiencies at the time of our December 28, 2015 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On January 12, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 4, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 20, 2015, as of January 4, 2016.

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

Benedictine Living Community Of New London January 15, 2016 Page 2

letter of December 28, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 20, 2016, 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 January 20, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective January 20, 2016, is to be rescinded.

In our letter of December 28, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 20, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 4, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On January 11, 2016,
I, Tames Fryensol , CEO/ABMINISTRATOR, received (Name)(Please Print) (Title)(Please Print) the Notice of Penalty Assessment dated January 11, 2016 and licensing orders issued to:
Benedictine Living Community Of New London 100 Glen Oaks Drive New London, MN 56273
The Penalty Assessments and licensing orders attached hereto have been corrected as of 1-/1-16.
Signed:
DELIVERY OF LICENSING PENALTY ASSESSMENT NOTICE
On January 11, 2016,
I,Austin Fry, Nurse Evaluator II_, of the Division of Compliance Monitoring, Minnesota Department of Health, delivered the Notice of Penalty Assessment dated January 11, 2016 and issued to:
Benedictine Living Community Of New London 100 Glen Oaks Drive New London, MN 56273
The Notice of Penalty Assessment was handed to, (Name)(Please Print)
Aprini stant , Date 11116 (Title)(Please Print)
Signed: , RN 1/2E VEII , Date // Name)(Please Print) (Title)(Please Print)



Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on January 11, 2016. January 11, 2016

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

Re: Project # S5360027

Dear Mr. Ingersoll:

On December 16, 2015, 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 October 20, 2015 with orders received by you on November 6, 2015.

State licensing orders issued pursuant to the last survey completed on October 20, 2015, found not corrected at the time of this December 16, 2015 revisit and subject to penalty assessment are as follows:

20565 -- MN Rule 4658.0405 Subp. 3 -- Comprehensive Plan Of Care; Use - \$300 20895 -- MN Rule 4658.0525 Subp. 2.B -- Rehab - Range Of Motion - \$350

The details of the violations noted at the time of this revisit completed on December 16, 2015 (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, sign and date this form or return it 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 \$650.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until written 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, 3333 W Division, #212 St Cloud Mn 56301.

Benedictine Living Community Of New London January 11, 2016 Page 2

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

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245360	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/12/2016
Name	of Facility		Street Address, City, State, Zip Code	
BE	NEDICTINE LIVING COMMUNITY OF NE	EW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273	

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

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0282		01/04/2016		ID Prefix	F0318		01/04/2016		ID Prefix			_
ŭ	483.20(k)(3)(ii)				•	483.25(e)(2)				Reg. #			_
LSC					LSC				Щ.	LSC			_
			.										
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg.#					Reg. #			•					_
LSC					LSC					LSC			_
									+-		-		
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix			-		ID Prefix			_
Reg. #					Reg. #					Reg. #			_
LSC					LSC				┷.	LSC			_
			Composition					Compation					Composition
			Correction Completed					Correction Completed					Correction Completed
ID Prefix			Completed		ID Prefix					ID Prefix			_
Reg.#					Reg. #					Reg. #			
					LSC					LSC			
									+				
			Correction					Correction					Correction
ID Profix			Completed		ID Profix			Completed		ID Profiv			Completed
Reg. # LSC					Reg. # LSC					Reg. #			_
					LSC				+-	LSC			
Reviewed By	Rev	riewed B	Ву	Da	te:	Signature of	Surve	yor:				Date:	
State Agency	<u>, </u>	E	BF/KJ	01.	/15/201			3392	25			01	/12/2016
Reviewed By	Rev	iewed B	Ву	Da		Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed	on:				Check fe	or anv	Uncorrected I	Defic	iencies. Was	a Summary of	1	
	10/20/20	15					-				to the Facility?	YES	NO
									_				

(Y1) Provider / Supplier / CLIA / (Y2) Multiple Construction

Identification NumberA. Building00314B. Wing

(Y3) Date of Revisit 1/12/2016

Name of Facility

BENEDICTINE LIVING COMMUNITY OF NEW LONDON

Street Address, City, State, Zip Code

100 GLEN OAKS DRIVE NEW LONDON, MN 56273

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4) Item		(Y5)	Date
		Correction			Correction				Correction
ID D . C		Completed	15.5 %		Completed	10.5			Completed
ID Prefix	20565	01/04/2016	ID Prefix	20895	01/04/2016		refix		_
U	MN Rule 4658.0405 Subp.			MN Rule 4658.0525 Subp.		R	eg.#		_
LSC			LSC		-	<u> </u>	LSC		_
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID F	refix		Completed
Reg. #		•	Reg. #						
					-		LSC		_
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix			ID Prefix		-	ID F	refix		_
Reg. #			Reg. #		_	I	eg.#		_
LSC			LSC		-		LSC		
		Correction			Correction				Correction
ID D . C		Completed	15.5 %		Completed	10.5			Completed
					-		refix		_
Reg. #			Reg. #				eg. #		_
LSC			LSC				LSC		_
		Correction			Correction				Correction
ID Profix		Completed	ID Profix		Completed	ID E	rofiv		Completed
		-			-		refix		_
Reg. # LSC			Reg. #		-	I	eg.#		_
			LSC				LSC		
			D. I.						
Reviewed By	Reviewed E	-	Date:	Signature of Surve	-	2025		Date:	1201
State Agency		BF/KJ	01/15/20	16	3	3925		01/12	/2016
Reviewed By CMS RO	Reviewed E	Зу	Date:	Signature of Surve	eyor:			Date:	
Followup to	Survey Completed on: 10/20/2015			_			Was a Summary Sent to the Facil		NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: C6FZ

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY AC	GENCY	F	acility ID: 00314	
MEDICARE/MEDICAID PROVI (L1) 245360 STATE VENDOR OR MEDICAID (L2) 770057500		3. NAME AND ADI (L3) BENEDICTI (L4) 100 GLEN O (L5) NEW LONDO	NE LIVING CO AKS DRIVE			DON 56273	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE O (L9) 02/01/2011	F OWNERSHIP	7. PROVIDER/SUF		Y 09 ESRD	02 (L7		7. On-Site Visit 9. Other 8. Full Survey After Complaint		
8. ACCREDITATION STATUS: 0 Unaccredited 1 T	12/16/2015 (L34) (L10) UC other	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	DATE: (L35)	
11. LTC PERIOD OF CERTIFICATE From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	52 (L18) 52 (L17)	B. Not in Com	ce With quirements	n	2. Tec 3. 241 4. 7-D	hnical Personnel	6. Scope of Servic 7. Medical Direct 8. Patient Room S 9. Beds/Room	or	
14. LTC CERTIFIED BED BREAKE 18 SNF 18/19 5 (L37) (L3	SNF 19 SNF 2	ICF (L42)	IID (L43)		15. FACILITY M		(L15)		
16. STATE SURVEY AGENCY RE	MARKS (IF APPLICABLE S	SHOW LTC CANCELL	ATION DATE):						
17. SURVEYOR SIGNATURE		Date :			18. STATE SUF	RVEY AGENCY API	PROVAL	Date:	
Austin Fry,			01/12/2016	(L19)					
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAI	OFFICE OR	SINGLE STAT	E AGENCY		
DETERMINATION OF ELIGIE 1. Facility is Eligible 2. Facility is not Eligible	to Participate		PLIANCE WITH C	CIVIL	2.		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	-1513)	
22. ORIGINAL DATE OF PARTICIPATION 11/01/1986 (L24)	23. LTC AGREEM. BEGINNING (L41)		4. LTC AGREEMI ENDING DAT (L25)		VOLUNTARY 01-Merger, Clos 02-Dissatisfaction	on W/ Reimbursemer		eet Health/Safety	
25. LTC EXTENSION DATE: (L2*	27. ALTERNATIV A. Suspension B. Rescind Sus	of Admissions:	(L44) (L45)		03-Risk of Involu	intary Termination for Withdrawal	OTHER 07-Provider S 00-Active	Status Change	
28. TERMINATION DATE:	(L28)	. INTERMEDIARY/C	ARRIER NO.	(L31)	30. REMARKS				
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION (12/02/2015	DF APPROVAL DA	TE (L33)	Posted 02/1	2/2016 Co. ATION APPRO	VAT.		
	(===)			()	DETERMIN.	ALION ALL KO	41.7F		



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered January 15, 2016

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

RE: Project Number S5360027

Dear Mr. Ingersoll:

On December 28, 2015, we informed you that the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 20, 2016. (42 CFR 488.417 (b))

Also, we notified you in our letter of December 28, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 20, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on October 20, 2015, that included an investigation of complaint number H5360015, and lack of verification of substantial compliance with the health deficiencies at the time of our December 28, 2015 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On January 12, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 4, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 20, 2015, as of January 4, 2016.

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

Benedictine Living Community Of New London January 15, 2016 Page 2

letter of December 28, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 20, 2016, 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 January 20, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective January 20, 2016, is to be rescinded.

In our letter of December 28, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 20, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 4, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File



Electronically delivered December 28, 2015

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

RE: Project Number S5360027

Dear Mr. Ingersoll:

On November 9, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 20, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On December 13, 2015, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 30, 2015. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on October 20, 2015.

However, compliance with the health deficiencies issued pursuant to the October 20, 2015 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On November 9, we also informed you that if your facility had not achieved substantial compliance by November 29, 2015, the Department of Health would impose the following remedy:

• State Monitoring. (42 CFR 488.422)

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

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective January

Benedictine Living Community Of New London December 28, 2015 Page 2

20, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective January 20, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 20, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Benedictine Living Community Of New London is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 20, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, 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 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division

Benedictine Living Community Of New London December 28, 2015 Page 3

> 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov.

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

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 April 20, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Benedictine Living Community Of New London December 28, 2015 Page 4

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

PRINTED: 01/06/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245360	B. WING _		R 12/16/2015	
	PROVIDER OR SUPPLIER	UNITY OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	12/10/2013	_
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	completed on Dece certification tags that found on the CMS2 that were not found were issued at the to located on the CMS Because you are en signature is not req	nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as				
{F 282} SS=E	on-site revisit of you validate that substa regulations has bee your verification. 483.20(k)(3)(ii) SER PERSONS/PER CA		{F 282	2}	1/4/16	
	must be provided b	led or arranged by the facility y qualified persons in ch resident's written plan of				
	by: Based on interview facility failed to ensicare for 3 of 4 resident reviewed for restorated addition, the facility	or and document review, the cure staff followed the plan of lents (R3, R50 and R35) ative nursing services. In failed to follow the plan of lents (R53) observed during res.		Plan of correction F282 A: The residents identified well as all residents receiving restonursing services, are receiving rehab/ROM services as per their p care. All residents are receiving prassistance with their ADL's as per	orative lan of roper	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed

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

PRINTED: 01/06/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		SURVEY PLETED
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{F 282}	R3's annual Minimum 9/19/15, identified in impairment, require staff for bed mobilities staff members for the identified R3 had been been been been been been been bee	JRSING SERVICES um Data Set (MDS) dated R3 had moderate cognitive ed extensive assistance of two ty, and total dependence of two ty, and total dependence of two transfers. Further, the MDS illateral mobility impairments to tes, and received no days of f motion (ROM). ed 11/25/15, identified an if to complete ankle and foot totion (PROM) including rflexion, with 15 reps each tches up to three times weekly owsheets dated 10/1/15 - the ordered PROM had been	{F 28	32}	B: The care plans of all resider receiving rehab/ROM services were reviewed and updated as needed a assessed to match the treatment refor all residents receiving restorative nursing services. Review of our cusystem for communicating care neour CNA's was conducted and chawere implemented to assure each receiving assistance with their ADL per their plan of care. C: Detailed reviews and audits restorative treatment records have conducted to assure each resident receiving their rehab/ROM services their plan of care. Weekly meetings been established with a rehab team including the RN Case Managers, the facility COTA and the primary restorative aide. The interim DON also attends meetings. These meetings include review of each resident's participating progress with restorative nursing as a detailed check to assure accus with the resident's plan of care and treatment record. A new "care she created for the CNAs to assure each resident is receiving the care they report their plan of care. This care she includes detailed information about resident's ADL need as per their caplan. D: Weekly restorative meetings will continue to allow ongoing review of resident's restorative nursing plan.	e and ecords e rrent eds to nges client is 's as of the been is as per the eds the eds these the eds well racy et" was cheed as eet each are	

Facility ID: 00314

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{F 282}	receive PROM. When interviewed stated changes have restorative program the floor, a restorative sidents to get up provide restorative that rehab was gett and restorative ser completed as ident. R50's quarterly MD diagnoses of right-cardio vascular access he required extens for bed mobility an indicated R50 was. R50's care plan, up interventions to predirected restorative hamstring and add (range of motion) to R50's restorative flow that the string and Addrecommendations to shoulder, elbows reduce contracture recommendations. A review of R50's rethe following: -October 2015	on 12/16/15, at 1:19 p.m. DON we been made to the n, and if they are short NA's on tive NA may be pulled to assist for the day, then they return to services. DON was unaware ting pulled more in December, vices were not being tified by the care plan. OS, dated 10/22/2015, included sided hemiparesis due to cident (stroke), and indicated sive assistance of two persons defended transfers. The MDS also severely, cognitively impaired. Odated 11/2/2015 included event contractures, which is nursing staff to complete daily uctor stretches, and ROM or RUE (right upper extremity). Owsheet included the orders: fluctor stretches per therapy as resident tolerates; and RUE is and wrist in all planes to per therapy	{F 28		using a team approach. Audits of the restorative treatment records will be weekly x4 then monthly ongoing to all residents area receiving their rehab/ROM services as per their placare. These audits and their finding be discussed up to monthly at the 0 meeting for determination of ongoin need. DON/Designee will monitor/raudits to ensure completion and compliance. Progress will be revien QA meetings. We continue with one monitoring and education with CNA regarding the importance of following each resident's plan of care. E: Corrected 1-4-16	e done assure an of gs will QA ng eview wed at going	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
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ntation x 2 per 2015 b] x 7 days n interview sing assistes to be pure on the flood to the flood to the flood at them reso said "two eye," and the at times. up interviewed R50 fied the day o's did not a stretches er received	days, "no rehab" x 6 days) 8 of 15 opportunities ("pulled" on 12/15/15 at 9:37 ant (NA)-A stated she alled" from restorative to work or. NA-A said at time she will or until there is a replacement, esume the restorative duties. o additional NAs are trained for ey are also getting pulled to ew on 12/16/15, at 12:37 p.m., O's Restorative Flowsheets, tes marked "Pulled." NA-A receive daily hamstring and only 8 of 15 opportunities.	{F 2	32}	DEFICIENCY)		
ed nurse (F tches" were uarterly Mir 5, included tiffied R35 mobility and ted 1-2 time are plan ided intervention te with tranself. The ca	RN)- B said R50's "exercises e done by Rehab only. nimum Data Set (MDS), dated diagnoses of Parkinson's, required extensive assistance and transfers, and also indicated es during the reference period. entified impaired mobility, and ons to meet the goal to a nsfers and remain able to are directed "NuStep [a seated]					
THE BELL BELL OF SITE AND DESTRUCTION OF SHARES	ed From partition x 2 ber 2015 an interview raing assist es to be puron the floor on the floor o	TION DENTIFICATION NUMBER: 245360 PR SUPPLIER ZING COMMUNITY OF NEW LONDON SUMMARY STATEMENT OF DEFICIENCIES THE DEFICIENCY MUST BE PRECEDED BY FULL DILATORY OR LSC IDENTIFYING INFORMATION) Ded From page 3 Intation x 2 days, "no rehab" x 6 days) Ber 2015 8 of 15 opportunities ("pulled" Lb] x 7 days An interview on 12/15/15 at 9:37 Trising assistant (NA)-A stated she Les to be pulled" from restorative to work Lon the floor until there is a replacement, Loan then resume the restorative duties. So said "two additional NAs are trained for tive," and they are also getting pulled to	TION 245360 B. WING PRESUPPLIER FING COMMUNITY OF NEW LONDON SUMMARY STATEMENT OF DEFICIENCIES (HD EFICIENCY MUST BE PRECEDED BY FULL TAG) BUILDATORY OR LSC IDENTIFYING INFORMATION) FIND THE PROPERTY OF LSC IDENTIFYING INFORMATION FIND THE PROPERTY OF LSC IDENTIFY INFORMATION FIND THE PROPERTY OF LICENTY INFORMATION FIND THE PROPERTY INFORMATION F	TION DENTIFICATION NUMBER: 245360 B. WING PRESUPPLIER TING COMMUNITY OF NEW LONDON SUMMARY STATEMENT OF DEFICIENCIES THE DEFICIENCY MUST BE PRECEDED BY FULL JULATORY OR LSC IDENTIFYING INFORMATION) The deform page 3 That interview on 12/15/15 at 9:37 Thing assistant (NA)-A stated she es to be pulled" from restorative to work on the floor. NA-A said at time she will d to the floor until there is a replacement, can then resume the restorative duties. So said "two additional NAs are trained for tve," and they are also getting pulled to at times. Tup interview on 12/16/15, at 12:37 p.m., viewed R50's Restorative Flowsheets, fied the dates marked "Pulled." NA-A D's did not receive daily hamstring and ar stretches, and ROM services, and in their received only 8 of 15 opportunities. That interview on 12/16/15 at 1:45 p.m. an interview on 12/16/15 at 1:45 p.m. and interview on 12/16/15 at 1:45 p.m. by the intervi	TION 245360 B. WING 245360 B. WING PROPPLIER WING COMMUNITY OF NEW LONDON SUMMARY STATEMENT OF DEFICIENCIES HOPEICIENCY MUST BE PRECEDED BY FULL LIATORY OR LSC IDENTIFYING INFORMATION) BY TAG THE APPROPO DEFICIENCY TAG PROVIDERS PLAN OF CORRECTION SHOULD CROSS-REPERBENCED TO THE APPROPO DEFICIENCY) TO STATEMENT OF DESTRUCTION SHOULD CROSS-REPERBENCED TO THE APPROPO DEFICIENCY) TO STATEMENT OF DESTRUCTION SHOULD CROSS-REPERBENCED TO THE APPROPO DEFICIENCY) TO STATEMENT OF THE APPROPO DEFICIENCY TO STATEMENT OF THE APPROPO TO STATE	TION 245360 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON SUMMARY STATEMENT OF DEFICIENCIES HOPE DEVELL LATORY OF LSC IDENTIFYING INFORMATION) Bet From page 3 ration x 2 days, "no rehab" x 6 days) ber 2015 B of 15 opportunities ("pulled" bl) x 7 days an interview on 12/15/15 at 9:37 sing assistant (NA)-A stated she se to be pulled" from restorative duties. so said "two additional NAs are trained for ve," and they are also getting pulled to rat times. Tup interview on 12/16/15, at 12:37 p.m., viewed R50's Restorative Flowsheets, field the dates marked "Pulled." NA-A 25 did not receive daily hamstring and retretches, and ROM services, and in her received only 8 of 15 opportunities. A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MS 56273 SIMMARY STATEMENT OF DEFICIENCIES PRESENTED PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FREETIX TAGE FROM THE PROPRIATE DEFICIENCIES PRESENTED PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FREETIX TAGE FROM THE PROPRIATE DEFICIENCIES PRESENTED PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FREETIX TAGE FROM THE PROPRIATE PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY FREETIX TAGE FROM THE PROPRIATE PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY FREETIX TAGE FROM THE PROPRIATE PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED PROPRIATE PLAN OF CROSS-REFERENCED PROPRIATE PLAN OF CROSS-REFERENCED PROPRIATE PLAN OF CROSS-REFERENCED PROPRIATE PLAN OF

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{F 282}	nursing flow sheets indicate R35 had evexercise therapy the by the care plan. During an interview NA-A stated she was assists the resident but R35 "has never Even though R35 creceive the NuStep facility has not imple MORNING CARES R53's quarterly Min 9/4/2015, identified dementia and histo (stroke), and furthe extensive assistant hygiene, including bindicated R53 was impaired. The care plan, date required extensive condition requires, bathing and person During observation nursing assistant (Nobegin morning care the room to assist R53's upper and low hands, arms and un assisted NA-D to rowhile changing his indicated care the romand of the room to assist R53's upper and low hands, arms and un assisted NA-D to rowhile changing his indicated R53 has a low hands, arms and un assisted NA-D to rowhile changing his indicated R53 has a low hands, arms and un assisted NA-D to rowhile changing his indicated R53 has a low hands, arms and un assisted NA-D to rowhile changing his indicated R53 has a low hands arms and un assisted NA-D to rowhile changing his indicated R53 has a low hands arms and un assisted NA-D to rowhile changing his indicated R53 has a low hands arms and un assisted NA-D to rowhile changing his indicated R53 has a low hands arms and un assisted NA-D to rowhile changing his indicated R53 has a low hands arms and un assisted NA-D to rowhile changing his indicated R53 has a low hands a low han	dical record and restorative for December 2015 did not ver received the NuStep ree times a week as identified on 12/16/15 at 12:52 p.m., as the restorative aide, that is with the NuStep exercises been on the NuStep list." are plan identified she was to exercises 3 times a week, the emented the care plan. imum Data Set, dated diagnoses which included ry of cardio-vascular accident r indicated R53 required se to complete personal prushing teeth. The MDS also moderately, cognitively and 12/14/2015, identified R53 assistance of 1-2 staff, as "with dressing, grooming,	(F 2	32}				

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED		
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{F 282}	his Broda chair (a oral care, nor sharfor R53 during this NA-D pushed R53 area and was serv. In an interview on member (FM)-A sr R53 was "frequen unshaven, often heals, and "did not FM-A stated that was one of R53's call was not able to ge has in the past, ar unshaven, or not lead to the state of R53's call was not able to ge has in the past, ar unshaven, or not lead to the state of R53's call was not able to ge has in the past, ar unshaven, or not lead to the state of R53's chair into bed, his and found dry, and NA-D did not offer cares for R53 during the linear and the state of R53 was not any oral cares eith shaving was "usually oral cares eith shaving was "usually and before bre NA-D said providing "personal hygiener resident," and the morning cares we buring an interview the director of nur	ansferred R53 from his bed into type of wheel chair). Neither ving assistance was provided a observation. At 8:20 a.m., by wheel chair into the dining ved breakfast. 12/16/2015 at 9:32 a.m. family tated when she came to facility, thy unkempt" because he was ad food on his shirts after of have oral cares completed." when in the facility, she often did res. Presently FM-A stated she of to the facility as often as she had when she sees R53 having teeth care, "I'm very akfast meal at 9:55 a.m. on was transferred from the wheel incontinent brief was checked did was positioned in bed. The for provide shaving or oral ng this time. 12/16/2015 at 1:55 p.m., NA- Do the shaved and "did not receive her." NA-D said oral care and ally done when a resident gets akfast" or right after breakfast. In goral cares was a part of and grooming, really for every re was "no reason" why R53's	{F 28	2}				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED			
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{F 318} SS=D	that she would experesident needs and residents." Resident A facility policy titled August 2006, identification used in developing routines and will be who have responsitives to the residents. IN RANGE OF MORE	de of R53's concern, and also ect the same following of care plans "for all the t #53" d Using the Care Plan, dated fied the care plan shall be the resident's daily care available to staff personnel collity for providing care or dent. EASE/PREVENT DECREASE TION Trehensive assessment of a must ensure that a resident of motion receives ent and services to increase d/or to prevent further	{F 28		1/4/16	
	by: Based on interview facility failed to consmotion (ROM) serv and 50) in the samp nursing services. Findings include: R3's annual Minimu 9/19/15, identified Fimpairment, require staff for bed mobility	AT is not met as evidenced and document review the sistently provide range of ices for 2 of 4 residents (R3 ole reviewed for restorative) The difference of two years of the providence of two ransfers. Further, the MDS		Plan of Correction F 318 A: The residents identified well as all residents care planned to receive rehab/ROM services are rerehab/ROM services as per their placare. B: All restorative treatment records care plans were reviewed for all restreceiving rehab/ROM services. C: Education provided to all staff on importance of not pulling the rehab	ceiving an of sand idents	

AND DUAN OF CORDECTION DENTIFICATION NUMBER.		` '	IPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
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{F 318}	identified R3 had be the lower extremitic completed range of R3's care plan data intervention for stap passive range of nodorsiflexion, plantate foot, heel cord streats R3 tolerates. R3's Restorative Fidentified an order dorsiflexion (toes undownward) 15 repostretches (toes upperference to each Sunday, Tuesday, times per week. Review of R3's Resulting 10/1/15 - 12/15/15 documented as considered as consi	polilateral mobility impairments to es, and received no days of of motion (ROM). ed 11/25/15, identified an ff to complete ankle and foot notion (PROM) including arflexion, with 15 reps each etches up to three times weekly ellowsheet dated 1/23/15, for ankle and foot PROM upward), plantarflexion (toes is each foot. Heel cord ward and hold 30 seconds, foot/ankle). Once a day and Thursday, up to three estorative Flowsheets dated identified PROM had been impleted as follows:	{F 31	to the floor. Additional staff of the rehab aide role. Weekly were formed and have beer consistently to discuss and residents' participation and restorative nursing. Attending meeting weekly are the RN Managers, the facility COT primary rehab aide. The integrated attends these meetings as a D: The staffing coordinator of assure there is a rehab aide days per week. The restorate team will continue to meet of basis ongoing. Audits of the treatment records of all resist participating with rehab will weekly x4 then monthly ong that all residents who receives ervices are receiving these care planned. These audits findings will be discussed at meetings up to monthly for of their ongoing need. DON monitor/review audits to enscompletion and compliance be reviewed at QA meetings. E: Corrected 1-4-16	meetings in held review all progress with ing this Case A and the erim DON also able. continues to e at least 5 tive/Rehab on a weekly e restorative dents be done loing to assure re rehab/ROM e services as and their t the QA determination l/Designee will sure . Progress will	

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245360	B. WING				∃ 16/2015	
	PROVIDER OR SUPPLIER	UNITY OF NEW LONDON		1	STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	1 12/	10/2010	
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
{F 318}	receive PROM. She crossed trained to p services. A restoration Wednesday, incomplete the restoration on Wednesday, incomplete the restoration and the rapy assistant (Coronal Rapidal	were left blank, R3 did not e stated not all NAs are provide the restorative tive committee meets weekly luding herself, occupational DTA), and registered nurse tated the director of nursing prese are in charge of the director of nursing preses are in charge of the director to services once when they were also verified the committee director two weeks ago. S, dated 10/22/2015, included pairment, and had a sided hemiparesis due to ident (stroke), and required the of bed mobility and dated 11/2/2015 included went contractures, which nursing staff to complete daily actor stretches, and ROM of RUE (right upper extremity). Dowsheets identified "Hamstring thes per therapy as resident tolerates, once per ion, "RUE [right upper ler, elbow and wrist in all ontracture per therapy	{F 3	18}				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245360	B. WING				R 16/2015
	PROVIDER OR SUPPLIER	UNITY OF NEW LONDON		ST 10	REET ADDRESS, CITY, STATE, ZIP CODE O GLEN OAKS DRIVE EW LONDON, MN 56273	1 12/	10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 318}	During an interview a.m.,nursing assista "continues to be pu as a NA on the floo be pulled to the floo and she can then re NA-A also said "two restorative," and the the floor and they we during this time. In follow up intervie NA-A reviewed R50 and verified the dat not received the da stretches, and RON only received 8 of 1 During an interview registered nurse (R and stretches" were when interviewed stated changes have restorative program being trained in. She short on the floor, the pulled to assist in g and they return to p DON also stated the	s completed: 14 of 31 opportunities (no la days) 23 of 30 opportunities (no days, "no rehab" x 6 days) 8 of 15 opportunities ("pulled"	{F3	18}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		245360	B. WING			R / 16/2015
	PROVIDER OR SUPPLIER	UNITY OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP CO 100 GLEN OAKS DRIVE NEW LONDON, MN 56273		10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
{F 318}	unaware that nursir more in December,	ige 10 Its weekly. The DON was ing rehab was getting pulled and restorative services were d for the residents as directed.	{F 3·	18}		

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA /	(Y2) Multiple Construction		(Y3) Date of Revisit	
	Identification Number	A. Building		12/16/2015	
	245360 B. Wing			12/10/2013	
Name of Facility			Street Address, City, State, Zip Code		
BENEDICTINE LIVING COMMUNITY OF NEW LONDON			100 GLEN OAKS DRIVE		
			NEW LONDON, MN 56273		

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

(Y4) Item		(Y5)	Date	(Y4)	Item			(Y5)	Date	(Y4)	Item	((Y5)	Date
ID Prefix	F0157		Correction Completed 11/19/2015		ID Prefix	F024	2		Correction Completed 11/30/2015		ID Prefix	F0279		Correction Completed 11/01/2015
Reg. # LSC	483.10(b)(11)		-		Reg. # LSC	483.15	(b)				Reg. # LSC	483.20(d), 483.2	0(k)(1)	_ _
ID Prefix Reg. # LSC	483.25		Correction Completed 11/30/2015		ID Prefix Reg. # LSC	F031 ²			Correction Completed 11/30/2015			F0312 483.25(a)(3)		Correction Completed 11/30/2015
ID Prefix Reg. # LSC	F0314 483.25(c)		Correction Completed 11/30/2015		ID Prefix Reg. # LSC	F031:			Correction Completed 11/30/2015		ID Prefix Reg. # LSC	F0353 483.30(a)		Correction Completed 11/30/2015
	F0431 483.60(b), (d),		Correction Completed 11/30/2015		ID Prefix Reg. # LSC	F044 483.65			Correction Completed 11/30/2015			F0520 483.75(o)(1)		Correction Completed 11/30/2015
ID Prefix Reg. # LSC			-		ID Prefix Reg. # LSC									
Reviewed By		Reviewed I	Ву	Da	te:		Signature of	Surve	yor:			·	Date:	
State Agency	/	BF/KJ		12/	/30/201	5			32	261	3		12/1	6/2015
Reviewed By CMS RO		Reviewed I	Ву	Da	te:		Signature of	Surve	yor:				Date:	
Followup to	Survey Compl	eted on: 0/2015				·		-				a Summary of to the Facility?	YES	NO

PRINTED: 01/06/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	00214		B. WING		F		
		00314		b. Wind		12/1	6/2015
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
BENEDIO	CTINE LIVING COMM	I INITY OF NEW I	-	OAKS DRI\ DON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 000}	Initial Comments			{2 000}			
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surver found that the deficiency found that the deficiency found that the deficiency for the matter of the Minnesota Department of the Minnesota Department of the Minnesota Tequirements of the number and MN Ruwhen a rule contain comply with any of lack of compliance.	hether a violation has bee	ued it is d ation nce of en				
	result in the assess	ment of a fine even if the uring the initial inspection	e item				
	that may result from orders provided tha the Department witl	hearing on any assessment non-compliance with the strategy and the strateg	ese de to				
		nsing revisit was complet 015. Licensing orders for					
	and will be reviewed	orders will remain in effed d at the next onsite visit, will be reviewed for poss	all				

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Electronically Signed

Minnesota Department of Health							
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
					R		
		00314	B. WING			6/2015	
					<u> </u>	0,2010	
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
BENEDIO	CTINE LIVING COMM	IINITY OF NEW I	N OAKS DRI				
		NEW LO	NDON, MN 5	6273			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROPERTY.		DATE	
		·		DEFICIENCY)			
{2 000}	Continued From no	ngo 1	{2 000}				
{2 000}	Continued From pa	ige i	{2 000}				
	penalty assessmen	nts.					
{2 565}	MN Rule 4658.0409	5 Subp. 3 Comprehensive	{2 565}			1/4/16	
	Plan of Care; Use						
		omprehensive plan of care					
		I personnel involved in the					
	care of the resident	ι.					
	This MN Requireme	ent is not met as evidenced					
	by:						
		on the following findings. The	•	Plan of correction			
		rder issued on October 20,		F282 A: The residents identified			
		effect. Penalty assessment		as all residents receiving restorative	re		
	issued.			nursing services, are receiving	lon of		
	Based on interview	and document review, the		rehab/ROM services as per their p care. All residents are receiving p			
		ure staff followed the plan of		assistance with their ADL's as per			
		dents (R3, R50 and R35)		plans of care.	trion		
		ative nursing services. In		plane of care.			
		failed to follow the plan of		B: The care plans of all reside	ents		
		dents (R53) observed during		receiving rehab/ROM services wer			
	routine morning car	res.		reviewed and updated as needed			
				assessed to match the treatment r			
	Findings include:			for all residents receiving restorative			
		IDCING CEDVICES		nursing services. Review of our co			
		JRSING SERVICES um Data Set (MDS) dated		system for communicating care ne our CNA's was conducted and cha			
		R3 had moderate cognitive		were implemented to assure each			
		ed extensive assistance of two		receiving assistance with their ADI			
		ty, and total dependence of two		per their plan of care.	_ 5 45		
		ransfers. Further, the MDS		per men plan el dalle.			
		ilateral mobility impairments to		C: Detailed reviews and audit	s of the		
		es, and received no days of		restorative treatment records have			
	completed range of	f motion (ROM).		conducted to assure each resident			
				receiving their rehab/ROM service	s as per		

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Minnesota Department of Health STATE FORM

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COM	SURVEY PLETED R 16/2015
00314 B. WING 12	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
BENEDICTINE LIVING COMMUNITY OF NEW L 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	1
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 565} Continued From page 2 {2 565}	
R3's care plan dated 11/25/15, identified an intervention for staff to complete ankle and foot passive range of motion (PROM) including dorsiflexion, plantarflexion, with 15 reps each foot, heel cord stretches up to three times weekly as R3 tolerates. R3's Restorative Flowsheets dated 10/1/15 - 12/15/15, identified the ordered PROM had been documented as completed as follows: October 2015 4 of 13 opportunities - November 2015 8 of 13 opportunities - December 2015 2 of 7 opportunities November 2015 8 of 13 opportunities - December 2015 2 of 7 opportunities with floor until there is a replacement and she can then resume the restorative duties. Two additional NAs are trained for restorative, and they are also getting pulled to the floor at times. When interviewed on 12/16/15, at 12:37 p.m. NA-A reviewed R3's Restorative Flowsheets, and verified if the dates are left blank R3 did not receive PROM. When interviewed on 12/16/15, at 1:19 p.m. DON stated changes have been made to the restorative program, and if they are short NA's on the floor, a restorative NA may be pulled to assist residents to get up for the day, then they return to provide restorative services. DON was unaware that rehab was getting pulled more in December, and restorative services were not being completed as identified by the care plan. The plan of care. Weekly meetings have been eatablished with a rehab team including the RN Case Managers, the facility COTA and the primary restorative aide. The interim DON also attends these meetings. These meetings rolled the review of each resident's plan cided. The interim DON also attends these meetings. These meetings have been eatablished with a rehab team including the RN Case Managers, the facility COTA and the primary restorative aide. The interim DON also attends these meetings with the care and treatment record. A new "care sheet" was created for the CNAs to assure each resident's plan of care. D: Weekly restorative mursing as well as detailed check to assure each resident's plan of care. D: W	

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Minnesota Department of Health STATE FORM

A. BUILDING:	(X3) DATE SURVEY COMPLETED		
00314 B. WING	R 12/16/2015		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			
BENEDICTINE LIVING COMMUNITY OF NEW L 100 GLEN OAKS DRIVE NEW LONDON, MN 56273			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	BE COMPLETE		
(2 565) Continued From page 3 R50's quarterly MDS, dated 10/22/2015, included diagnoses of right-sided hemiparesis due to cardio vascular accident (stroke), and indicated she required extensive assistance of two persons for bed mobility and transfers. The MDS also indicated R50 was severely, cognitively impaired. R50's care plan, updated 11/2/2015 included interventions to prevent contractures, which directed restorative nursing staff to complete daily hamstring and adductor stretches, and ROM (range of motion) to RUE (right upper extremity). R50s restorative flowsheet included the orders: Hamstring and Adductor stretches per therapy recommendations as resident tolerates; and RUE to shoulder, elbows and wrist in all planes to reduce contracture per therapy recommendations. A review of R50's restorative flowsheets indicated the following: -October 2015 14 of 31 opportunities (no documentation of any kind on 17 days) -November 2015 23 of 30 opportunities (no documentation x 2 days, "no rehab' x 6 days) -December 2015 8 of 15 opportunities ("pulled" [no rehab] x 7 days During an interview on 12/15/15 at 9:37 a.m.,nursing assistant (NA)-A stated she "continues to be pulled" from restorative to work as a NA on the floor. NA-A said at time she will be pulled to the floor until there is a replacement, and she can then resume the restorative duties. NA-A also said "two additional NAs are trained for restorative," and they are also getting pulled to the floor at times. In follow up interview on 12/16/15, at 12:37 p.m.,			

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00314	B. WING			R 1 6/2015
					12/1	10/2013
NAME OF	PROVIDER OR SUPPLIER		N OAKS DRIV	STATE, ZIP CODE		
BENEDI	CTINE LIVING COMMI	INITY OF NEW I	NDON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 565}	Continued From pa	ge 4	{2 565}			
	NA-A reviewed R50 and verified the dat said R50's did not radductor stretches, December received During an interview registered nurse (Rand stretches" were R35's quarterly Min 9/25/2015, included and identified R35 rwith bed mobility and	o's Restorative Flowsheets, es marked "Pulled." NA-A receive daily hamstring and and ROM services, and in donly 8 of 15 opportunities. Ton 12/16/15 at 1:45 p.m. N)- B said R50's "exercises e done by Rehab only. Imum Data Set (MDS), dated diagnoses of Parkinson's, required extensive assistance and transfers, and also indicated es during the reference period				
	R35's care plan ide included interventio participate with tran propel self. The ca	ntified impaired mobility, and ons to meet the goal to insfers and remain able to re directed "NuStep [a seated up to 3x [three times] a week				
	nursing flow sheets indicate R35 had ev	dical record and restorative for December 2015 did not ver received the NuStep ree times a week as identified				
	NA-A stated she wa assists the resident	on 12/16/15 at 12:52 p.m., as the restorative aide, that as with the NuStep exercises been on the NuStep list."				
	receive the NuStep	are plan identified she was to exercises 3 times a week, the emented the care plan.				
	MORNING CARES					

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Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED							
		00314	B. WING		F 12/1	R 1 6/2015						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
BENEDICTINE LIVING COMMUNITY OF NEW L 100 GLEN OAKS DRIVE												
NEW LONDON, MN 562/3												
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE						
{2 565}	Continued From pa	ge 5	{2 565}									
	9/4/2015, identified dementia and histo (stroke), and furthe extensive assistant hygiene, including b	imum Data Set, dated diagnoses which included ry of cardio-vascular accident r indicated R53 required be to complete personal brushing teeth. The MDS also moderately, cognitively										
	required extensive	ed 12/14/2015, identified R53 assistance of 1-2 staff, as "with dressing, grooming, al hygiene."										
	nursing assistant (N begin morning care the room to assist F R53's upper and low hands, arms and ur assisted NA-D to rowhile changing his NA-E then assisted NA-D trainis Broda chair (a tyoral care, nor shavifor R53 during this	on 12/16/2015 at 8:03 a.m., NA)-C entered R53's room to s. At 8:07 a.m. NA-D entered R53, and completed washing wer body, including face, anderarms. Next, NA-C oll and reposition in the bed, incontinent product. NA-D and R53 to dress. At 8:18 a.m., ansferred R53 from his bed into type of wheel chair). Neither and assistance was provided observation. At 8:20 a.m., as wheel chair into the dining and breakfast.										
	member (FM)-A sta R53 was "frequently unshaven, often ha meals, and "did not FM-A stated that wh some of R53's care was not able to get has in the past, and	2/16/2015 at 9:32 a.m. family ated when she came to facility, y unkempt" because he was d food on his shirts after have oral cares completed." hen in the facility, she often did as. Presently FM-A stated she to the facility as often as she I when she sees R53 aving teeth care, "I'm very										

Minnesota Department of Health

STATE FORM 6899 C6FZ12 If continuation sheet 6 of 11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED							
			A. BUILDING:									
		00314	B. WING		F 12/1	1 6/2015						
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE								
BENEDICTINE LIVING COMMUNITY OF NEW L 100 GLEN OAKS DRIVE NEW LONDON, MN 56273												
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON SHOULD BE COMPLETE HE APPROPRIATE DATE							
{2 565}	Continued From page 6		{2 565}									
	upset."											
	10/16/2015, R53 w chair into bed, his in and found dry, and	Afast meal at 9:55 a.m. on as transferred from the wheel ncontinent brief was checked was positioned in bed. The or provide shaving or oral ag this time.										
	stated R53 was not any oral cares eithe shaving was "usual up and before brea NA-D said providing "personal hygiene a	12/16/2015 at 1:55 p.m., NA- D t shaved and "did not receive er." NA-D said oral care and lly done when a resident gets kfast" or right after breakfast. g oral cares was a part of and grooming, really for every e was "no reason" why R53's e not provided.										
	the director of nurs care plan needed to she "would take no that she would exp	on 12/16/2015 at 2:18 p.m., ing (DON) stated that "[R53's] be followed." The DON said te of R53's concern, and also ect the same following of care plans "for all the ht #53										
	August 2006, identiused in developing routines and will be	d Using the Care Plan, dated ified the care plan shall be the resident's daily care available to staff personnel bility for providing care or dent.										
{2 895}	MN Rule 4658.052 Motion	5 Subp. 2.B Rehab - Range of	{2 895}			1/4/16						
		motion. A supportive program ard prevention of deformities										

Minnesota Department of Health

STATE FORM 6899 C6FZ12 If continuation sheet 7 of 11

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED		
	00314				R 12/16/2	2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY,	STATE, ZIP CODE			
	CTINE LIVING COMM	100 GI F	N OAKS DRI				
BENEDI	CTINE LIVING COMM	NEW LO	NDON, MN 5	66273			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE C	(X5) COMPLETE DATE	
{2 895}	·		{2 895}				
	implemented and m comprehensive res of nursing services	and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which					
	receives appropriat	h a limited range of motion e treatment and services to notion and to prevent further of motion.					
	This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on October 20, 2015, will remain in effect. Penalty assessment issued. Based on interview and document review the facility failed to consistently provide range of			Plan of Correction F 318 A: The residents identified well as all residents care planned receive rehab/ROM services are rehab/ROM services as per their plant. B: All restorative treatment records	to eceiving blan of		
		ices for 2 of 4 residents (R3 ble reviewed for restorative		B: All restorative treatment recorcare plans were reviewed for all refreceiving rehab/ROM services.			
	9/19/15, identified Fimpairment, require staff for bed mobilit staff members for to identified R3 had bithe lower extremities completed range of R3's care plan date	Im Data Set (MDS) dated R3 had moderate cognitive and extensive assistance of two y, and total dependence of two ransfers. Further, the MDS lateral mobility impairments to es, and received no days of motion (ROM). d 11/25/15, identified an for to complete ankle and foot		C: Education provided to all staff of importance of not pulling the rehat to the floor. Additional staff were to the rehab aide role. Weekly meeting were formed and have been held consistently to discuss and review residents' participation and progres restorative nursing. Attending this meeting weekly are the RN Case Managers, the facility COTA and primary rehab aide. The interim D attends these meetings as able.	b aides rained in ngs all ess with		
		otion (PROM) including		D: The staffing coordinator continu	ues to		

Minnesota Department of Health

STATE FORM 6899 C6FZ12 If continuation sheet 8 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED	
					R
		00314	B. WING		12/16/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	
BENEDI	CTINE LIVING COMM	UNITY OF NEW I	OAKS DRI\ DON, MN 5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
{2 895}	Continued From pa	ge 8	{2 895}		
{2 895}	dorsiflexion, plantal foot, heel cord stret as R3 tolerates. R3's Restorative Fl identified an order f dorsiflexion (toes u downward) 15 reps stretches (toes upw three reps to each Sunday, Tuesday, a times per week. Review of R3's Res	or ankle and foot PROM pward), plantarflexion (toes each foot. Heel cord and hold 30 seconds, foot/ankle). Once a day and Thursday, up to three storative Flowsheets dated identified PROM had been	{2 895}	assure there is a rehab aide at leadays per week. The restorative/Reteam will continue to meet on a webasis ongoing. Audits of the restor treatment records of all residents participating with rehab will be dorweekly x4 then monthly ongoing to that all residents who receive rehaservices are receiving these servicare planned. These audits and the findings will be discussed at the Queetings up to monthly for determof their ongoing need. DON/Desigmonitor/review audits to ensure completion and compliance. Prog be reviewed at QA meetings.	hab pekly ative e assure b/ROM pes as eir A ination nee will
	restorative/nursing continues to be pull a NA on the floor. In the floor until there then resume the readditional NAs are they are also getting. When interviewed on NA-A reviewed R3's stated if the dates were receive PROM. She crossed trained to proceed to the services. A restoration on Wednesday, incomparison therapy assistant (CRN)-A. She also services as the services of the services are the services of the s	4 of 13 opportunities 8 of 13 opportunities 2 of 7 opportunities on 12/15/15, at 9:37 a.m. assistant (NA)-A stated she led from restorative to work as At times, she will be pulled to is a replacement and she can storative duties. Two trained for restorative, and g pulled to the floor at times. on 12/16/15, at 12:37 p.m. a Restorative Flowsheets, and were left blank, R3 did not be stated not all NAs are provide the restorative tive committee meets weekly luding herself, occupational DTA), and registered nurse stated the director of nursing urses are in charge of the		E: Corrected 1-4-16	

Minnesota Department of Health

STATE FORM 6899 C6FZ12 If continuation sheet 9 of 11

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00314				R	
		00314	B. WING		12/	16/2015	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
BENEDI	CTINE LIVING COMM	INITY OF NEW I	EN OAKS DRI ^N ONDON, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
{2 895}	Continued From pa	ge 9	{2 895}				
	restorative program	ı.					
	OTA stated she has provide restorative :	on 12/16/15, at 12:55 p.m. s covered on the floor to services once when they were also verified the committee d two weeks ago.	е				
	severe cognitive im diagnoses of right-s cardio vascular acc	S, dated 10/22/2015, include pairment, and had a sided hemiparesis due to ident (stroke), and required se of bed mobility and	d				
	interventions to pre- directed restorative hamstring and addu	dated 11/2/2015 included vent contractures, which nursing staff to complete da uctor stretches, and ROM o RUE (right upper extremity)					
	and Adductor stretc recommendations a day." Range of moti extremity] to should	as resident tolerates, once pe ion, "RUE [right upper ler, elbow and wrist in all ontracture per therapy					
	October to December following rehab was -October 2015 documentation on 1 -November 2015	14 of 31 opportunities (no 17 days) 23 of 30 opportunities (no days, "no rehab" x 6 days) 8 of 15 opportunities ("pulle	d"				

6899

Minnesota Department of Health STATE FORM

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		0004.4	B. WING		F	
		00314	B. WING		12/1	6/2015
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
BENEDI	CTINE LIVING COMM	INITY OF NEW I	I OAKS DRI\ IDON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 895}	During an interview a.m.,nursing assista "continues to be pu as a NA on the floor be pulled to the floor and she can then re NA-A also said "two restorative," and the the floor and they we during this time. In follow up intervie NA-A reviewed R50 and verified the dat not received the dastretches, and RON only received 8 of 1 During an interview registered nurse (Rand stretches" were When interviewed stated changes have restorative program being trained in. She short on the floor, the pulled to assist in gand they return to poon also stated the responsible to review progress of residen unaware that nursim more in December,	ge 10 on 12/15/15 at 9:37 ant (NA)-A stated she lled" from restorative to work r. NA-A said at time she will or until there is a replacement, esume the restorative duties. o additional NAs are trained for ey are also getting pulled to ere unable to provide rehab w on 12/16/15, at 12:37 p.m., b's Restorative Flowsheets, es marked "Pulled," R50 had illy hamstring, adductor of services. In December R50 on 12/16/15 at 1:45 p.m. N)- B said R50's "exercises of done by Rehab only. on 12/16/15, at 1:19 p.m. DON or been made to the or, with four additional staff the verified when the NAs are one restorative NA may be etting residents up for the day, by trovide restorative services. The RN case managers were of the flowsheets and the weekly. The DON was one grehab was getting pulled and restorative services were defor the residents as directed.	{2 895}			

Minnesota Department of Health STATE FORM

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00314	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/16/2015
Name	of Facility		Street Address, City, State, Zip Code	

BENEDICTINE LIVING COMMUNITY OF NEW LONDON

100 GLEN OAKS DRIVE NEW LONDON, MN 56273

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4) Item		(Y5) D	ate
		Co	orrection					Correction					Correction
ID Prefix	20255		ompleted /30/2015		ID Prefix	20265		Completed 11/19/2015		ID Prefix	20303		Completed 11/18/2015
		''	730/2013					11/19/2015					_
Reg. # LSC	MN Rule 4658.0070				Reg. # LSC	MN Rule 4658.0085				Reg. # LSC	MN State State	ute 144.6503	-
LSC				-	LSC				+	LSC			
		Co	orrection					Correction					Correction
			ompleted					Completed					Completed
ID Prefix	20560	11	/01/2015		ID Prefix	20800		11/30/2015		ID Prefix	20830		11/30/2015
•	MN Rule 4658.0405 S	Subp. 2			ū	MN Rule 4658.0510 S		1		Ü	MN Rule 4658.	0520 Subp.	1
LSC					LSC				_	LSC			
		Co	orrection					Correction					Correction
10.0.5			ompleted		ID D . C			Completed		ID D . C			Completed
ID Prefix	20900	11	/30/2015		ID Prefix	20910		11/30/2015		ID Prefix	20915		11/30/2015
•	MN Rule 4658.0525 S	Subp. 3			•	MN Rule 4658.0525 S	ubp. (5 A.I			MN Rule 4658.		
LSC				_	LSC				_	LSC			
		Co	orrection					Correction					Correction
		C	ompleted					Completed					Completed
ID Prefix	21390	11	/30/2015		ID Prefix	21830		11/30/2015		ID Prefix			-
Reg.#	MN Rule 4658.0800 S	Subp. 4 A	\-		Reg. #	MN St. Statute 144.6	51 Sub	od. 1		Reg. #			
LSC				_	LSC					LSC			
		Co	orrection					Correction					Correction
		C	ompleted					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			_
Reg.#					Reg. #					Reg. #			
LSC					LSC				\perp	LSC			<u> </u>
Reviewed By	Revie	wed By		Da	te:	Signature of	Surve	yor:				Date:	
State Agency	.]	BF/KJ		12,	/30/201	-		326	13			12/1	6/2015
Reviewed By CMS RO	Revie	wed By		Da	te:	Signature of	Surve	yor:				Date:	
Followup to	Survey Completed or			_							a Summary of to the Facility?	YES	NO
TATE FORM	I: REVISIT REPORT	(5/99				Page 1 of 1					Event ID:	C6F712	

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245360	(Y2) Multiple Constru A. Building B. Wing	N BUILDING 01	(Y3) Date of Revisit 12/13/2015
Name of Facility		Street Address, City, State, Zip Code	
BENEDICTINE LIVING COMMUNITY OF N	EW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273	

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

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	Item	((Y5)	Date
			Correction					Correction					Correction
ID Deefin			Completed		ID Danfin			Completed		ID Danfin			Completed
ID Prefix			11/25/2015					11/25/2015					
•	NFPA 101 K0056				-	NFPA 101 K0144				Reg. #			_
	K0030					K0144							_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			_
Reg.#					Reg. #					Reg. #			_
LSC					LSC					LSC			
			0 "					0 "					0 "
			Correction Completed					Correction Completed					Correction Completed
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			
Reg.#													
LSC					LSC					LSC			_
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg.#					Reg.#								_
										LSC			- -
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg.#					Reg.#					D #			
										LSC			_
Reviewed By	Revie	ewed B	Ву	Da	te:	Signature of	Surve	yor:				Date:	
State Agency	,	T	CL/KJ	12	/30/20	15		3476	54			01/	11/2015
Reviewed By	Revi	ewed B	Ву	Da	te:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed o	n:				Check fo	r any	Uncorrected I	Defic	iencies. Was	a Summary of		
	10/16/201	5				Unco	rrecte	d Deficiencies	(CM	IS-2567) Sent	to the Facility?	YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: C6FZ

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AG	ENCY		Facility ID: 00314
1. MEDICARE/MEDICAID PROVIDER N (L1) 245360 2.STATE VENDOR OR MEDICAID NO. (L2) 770057500	О.	3. NAME AND AD (L3) BENEDICTI (L4) 100 GLEN O (L5) NEW LOND	NE LIVING COM OAKS DRIVE			OON 56273	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	N: 2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9) 02/01/2011	NERSHIP	7. PROVIDER/SUI		Y 09 ESRD		22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other
6. DATE OF SURVEY 10/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDIN	IG DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds	52 (L18) 52 (L17)	Compliance X 1. A B. Not in Com	nce With equirements		2. Tech 3. 24 H 4. 7-Da 5. Life	nical Personnel	E Following Requirements:	ector n Size
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 52	19 SNF	ICF	IID		15. FACILITY MI		(L15)	
(L37) (L38) 16. STATE SURVEY AGENCY REMARK	(L39) ES (IF APPLICABLE S	(L42) HOW LTC CANCELI	(L43) LATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	VEY AGENCY AP	PROVAL	Date:
Mardelle Tret	tel, HFE NE	II	11/30/2015	(L19)	Kate Joh	nsTon, Pr	ogram Special	ist 12/01/2015 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAI	OFFICE OR S	SINGLE STAT	E AGENCY	
DETERMINATION OF ELIGIBILITY			IPLIANCE WITH C HTS ACT:	IVIL	2. (ial Solvency (HCFA-2572) interest Disclosure Stmt (HC	CFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 11/01/1986 (L24)	23. LTC AGREEMI BEGINNING (L41)		24. LTC AGREEME ENDING DATI		26. TERMINAT VOLUNTARY 01-Merger, Closu 02-Dissatisfaction	00	05-Fail to	(L30) NTARY Meet Health/Safety Meet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension of B. Rescind Sus	of Admissions:	(L44)		03-Risk of Involu	•	OTHER 07-Provid 00-Active	er Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/C	(L45) CARRIER NO.		30. REMARKS			
	(L28)	03001		(L31)	D	21/2015 C		
31. RO RECEIPT OF CMS-1539	(L32)	DETERMINATION (OF APPROVAL DAT	ΓΕ (L33)		01/2015 Co. ATION APPRO	VAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered November 9, 2015

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

RE: Project Number S5360027

Dear Mr. Ingersoll:

On October 20, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the October 20, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5360015.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

Benedictine Living Community Of New London November 9, 2015 Page 2

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

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

Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 29, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 29, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

Benedictine Living Community Of New London November 9, 2015 Page 4

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 January 20, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 20, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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, Interim Supervisor Health Care Fire Inspections State Fire Marshal Division Email: tom.linhoff@state.mn.us Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johns Ton, Program Specialist Licensing and Certification Program

Health Regulation Division kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

PRINTED: 12/01/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	<u> </u>		SURVEY PLETED
		245360	B. WING			1	C
NAME OF D	ROVIDER OR SUPPLIER	245360	B. WING _	etheet annhees	S, CITY, STATE, ZIP CODE	10	/20/2015
NAME OF PI	ROVIDER OR SUPPLIER			100 GLEN OAKS			
BENEDIC	TINE LIVING COMMUNI	TY OF NEW LONDON		NEW LONDON,			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACI	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD B F-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENT	S	F	00			
F 157 SS=D	as your allegation of Department's accept enrolled in ePOC, you at the bottom of the form. Your electronic be used as verification be used as verification upon receipt of an accomplaint envisition of the recomplaint investigat time of the standard complaint investigat time of the standard complaint H536001 substantiated with defaulted with defaulted with the standard complaint H536001 substantiated with defaulted with defaulted with the standard complaint H536001 substantiated with defaulted with the substantiated with defaulted with the resistance or an interested farm accident involving the injury and has the pointervention; a significant physical, mental, or deterioration in healt status in either life the clinical complication significantly (i.e., a rexisting form of treat	r facility may be conducted to nitial compliance with the nattained in accordance with ertification survey, a ion was also completed at the survey. An investigation of 5 was completed and eficiencies issued at F157.	F	57			11/19/15
		sion to transfer or discharge					
ABORATORY	DIRECTOR'S OR PROVIDER	NSUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE

Electronically Signed 11/18/2015

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245360	B. WING		C 10/20/2015		
NAME OF P	ROVIDER OR SUPPLIER	****		STREET ADDRESS, CITY, STATE, ZIP CODE	10/20/2013		
				100 GLEN OAKS DRIVE			
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		NEW LONDON, MN 56273			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 157	Continued From page	e 1	F 15	7			
	the resident from the §483.12(a).	facility as specified in					
	and, if known, the resor interested family mechange in room or roospecified in §483.15(resident rights under regulations as specifithis section. The facility must record the address and phore	Federal or State law or ed in paragraph (b)(1) of rd and periodically update ne number of the resident's					
	In this REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify residents' families in a timely manner for 1 of 1 residents (R2) with an elevated laboratory value that needed physician involvement and for 1 of 1 residents (R55) who was administered another resident's medications in error. Findings include: R2's significant change Minimum Data Set (MDS) dated 9/1/15, identified R2 had severe cognitive impairment, and had long term use of anticoagulant medication (used to thin the blood). R2's physician orders dated 10/14/15, identified R2 was prescribed coumadin, a medication to prevent strokes by thinning the blood which is monitored with a laboratory value called an			A: Families of both residents were notified of the elevated INR and the medication error. Notifications compl B: We identified that all residents on Coumadin or are involved in a medical error could be affected by this, as the process will be for all residents as stabelow. All have had the appropriate notification. C: Notification policy was reviewed and describes the notification to family/MI an elevated INR (> 0.5 points above resident soal range and requiring rordered medications). Staff was educ on our updated notification policy and documentation of notification. D: 10% of the resident population sprogress notes will be audited by DOI designee for family notifications week	ation ted of newly ated		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		PLETED
		245360	B. WING _				C 20/2015
NAME OF PROVIDER OF BENEDICTINE LIV		TY OF NEW LONDON		10	TREET ADDRESS, CITY, STATE, ZIP CODE 00 GLEN OAKS DRIVE EW LONDON, MN 56273	1 10/	20/2010
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
R2's fa 8/5/15, but her twice it wrote a Vitamir thinnin [milligrate of the work of the wo	identified R2 most recent he INR goal for an order, "Adjin K [medication g effects from ams] p.o. [by medical record ion R2's familiated INR which ment and a man effect of the interview on red nurse (RN cantly outside and the reside "should be not the have been in 5, and nursin enting the not interviewed or stated the familiated the familiated the familiated the reside cantly out of red d with her can red with her can red with her can red with required ty Change in a policy dated s Supervisor/CI	tion from the physician dated 's INR goal was "2.0 - 3.0", value was "7.9", more than or R2. Further, the physician ust coumadin to: Hold 8/5/15; on used to reverse the blood a coumadin] 2.5 mg mouth] today." was reviewed, there was no y had been notified of R2's required a physician nedication to correct the e coumadin, with a high INR. 10/19/15, at 1:59 p.m. N)-A stated when an INR is "of their established goal ent requires Vitamin K, the tified." Further, R2's family notified" since her INR was g staff should be tification in R2's progress 10/20/15, at 8:35 a.m. hilly should be notified of all ents, not just when they are ange. R2's family is very re, and they should have lified of R2's increased INR	F	157	quarterly throughout the following year with results reported to Quality Council		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION G	l \ /	TE SURVEY MPLETED	
		245360	B. WING		1	C 0/20/2015
	ROVIDER OR SUPPLIER	TY OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	•	0/20/2010
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F 157	Continued From pag physical, mental, or	ge 3 psychosocial status."	F 1	57		
		mum Data Set (MDS) dated 55 had severe cognitive				
	family member (FM) not being notified of R55 in a timely man wrong medication by was not notified of th	on 10/13/2015, at 10:24 a.m. -A stated she upset regarding a medication error involving ner. R55 was given the y staff on 5/2/15, but FM-A ne error until two days later on d "an incidental meeting" with er.				
	R55's nursing progress notes dated 5/2/15 to 5/4/15, identified the following: > 5/2/15 - "Resident pleasant this shift with no negative behaviors noted. Med error performed by TMA, resident was given [another resident's] 2000 [8 p.m.] medications instead of her own. Passed on to monitor resident throughout the night for any adverse effects to medications. MD faxed. Supervisor notified. No adverse effects noted thus far." > 5/3/2015 - "Res [resident] has been in a pleasant mood this shift. No SE [side effects] noted from med error from last evening." > 5/4/2015 - "Res alert this shift w/occ [occasional] muttering noted. Appetite fair, eating 75% [percent] of breakfast, did feed self but needed occ ques [sic] to eat. Fluids enc [encouraged]. No nausea voiced." > 5/4/2015 - "Drt. [daughter] [of R57] notified of med error over the weekend. She asked for a list of the meds that were given to her incorrectly." The family was notified 2 days after the incident					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245360	B. WING _			C 10/20/2015		
	ROVIDER OR SUPPLIER	TY OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZI 100 GLEN OAKS DRIVE NEW LONDON, MN 56273				
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F 157	Continued From pag	ge 4	F 1	157				
		d was reviewed and lacked had been notified of the or to 5/4/15.						
	registered nurse (RN working when the er RN-C notified the su faxed the physician did not notify R55's she was aware FM-care, shrugged her s	on 10/15/2015, at 8:48 a.m. N)-C stated she had been ror was reported on 5/2/15. Spervisor of the error, and to update him, but added she FM-A about it. RN-C stated A was "very involved" in R55's shoulders and stated, "I think been notified sooner."						
	the social worker (S' changes" in regard t give FM-A notification been notified of the	n 10/16/2015, at 10:09 a.m. W) stated "for any little o R55's care, staff know to on adding FM-A should have medication error, "Without ould have been notified."						
	the director of nursir error occurred, the fa include "timely notific [resident's] family."	on 10/16/2015, at 11:56 a.m. ag (DON) stated since the acility revised its policy to cation or update of the Further, the DON stated een "notified right away" after wrong medications.						
F 242	Error Involving Admi Medications policy u "All sections of the 'I for Resident Given in completed as soon a notification of physic	Resident Post Medication nistration of Incorrect pdated 6/1/2015, identified, Medication Error Report Form ncorrect Medication' must be as possible; this includes cian and family." TERMINATION - RIGHT TO	F 2	242		11/30/15		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245360	B. WING _			1	20/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	1 10/	20/2010
DENEDIO:	FINE I WING COMMUNIT	V OF NEW LONDON		100 GLEN OAKS DRIVE			
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		NEW LONDON, MN 56273			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG				(X5) COMPLETION DATE
F 242 SS=D	MAKE CHOICES The resident has the schedules, and health her interests, assessinteract with members inside and outside the about aspects of his care significant to the data are significant to the da	right to choose activities, in care consistent with his or ments, and plans of care; is of the community both a facility; and make choices or her life in the facility that resident. The is not met as evidenced in, interview and document and to following morning or 1 of 1 residents (R24) atted 7/22/15, indicated R24 and required extensive to complete his activities of in 10/12/15, at 6:15 p.m. R24 are up in the morning by 6:30	F 2	A: This resident s preferent early is being honored. B: Preferences interviews and completed with all residents care plans reflects individual preferences. C: Information re: whether plane being honored will be accompleted at Resident care cand Resident Council. D: 10% of the resident popular	re being to ensure for to ensure for the standard and conferences allation will be	that	
	that had not been hap it was 8:30 before the adding, "Sometimes I they are short of help A review of the Glenc nursing assistant care "Likes to get up at 5:30 During observation of	aks Care Center-Maple 2 e sheet, undated, included,		interviewed monthly, specifications times, exclusive of action Conferences and Resident Conferences and Resident Compositions will be the responded to the Quality Court of the Q	tivity in Car Council. Th nsibility of t ts will be	e is	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	I' '	(X3) DATE SURVEY COMPLETED		
		245360	B. WING _			C 10/20/2015		
	ROVIDER OR SUPPLIER TINE LIVING COMMUN	ITY OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP (100 GLEN OAKS DRIVE NEW LONDON, MN 56273	CODE	10/20/20 10		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 242	should be up by not 6:00 a.m." NA-A did During an interview NA-A stated he was get the residents wheating up first and g NA-A stated staff try can." Further, NA-A preference to be up When interviewed of LPN-C stated R24 ha.m. and 7:00 a.m., times "depends on whilding." Further, I did not typically help cares. During interview on stated, "[R24] likes shift won't do it. The NA-I stated R24 cortold the nurses, but When interviewed of director of nursing (enough staff to get but the goals was to choices." An undated facility of Determination and fithe facility, "Respected to each resident to execution only regarding and the facility, "Respected to each resident to execution only regarding and staff to get autonomy regarding each resident to execution only regarding each resident each resident to execution each resident each each resident each resident each resident each resident each res	on 10/14/15, at 8:49 a.m., "new here", but staff typically no require assistance with let everyone else up later. It to get to R24 "as soon as we awas unaware of R24's early. In 10/20/15, at 10:54 a.m. liked to be up between 5:30 but helping him during those what else is going on in the LPN-C stated the night shift or residents with morning 10/20/15, at 10:56 a.m. NA-I to get up at 5:30, but night ey make him wait." Further, implains to her and she has nothing has changed. In 10/16/15, at 12:02 p.m. the DON) stated there is often not residents up in the morning, o "to honor all resident	F 2	242				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ATE SURVEY DMPLETED
		245360	B. WING _			C 10/20/2015
	ROVIDER OR SUPPLIER	Y OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273		
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F 242 F 279 SS=D	care that are consisted interest, assessments 483.20(d), 483.20(k)(COMPREHENSIVE COMPREHENSIVE COMPR	tivities, schedules and health ent with her or her own and plans of care" 1) DEVELOP CARE PLANS e results of the assessment of revise the resident's of care. elop a comprehensive care that includes measurable bles to meet a resident's mental and psychosocial ied in the comprehensive escribe the services that are ain or maintain the resident's mysical, mental, and mg as required under vices that would otherwise 83.25 but are not provided exercise of rights under	F 2	42		11/1/15
	under §483.10(b)(4). This REQUIREMENT by: Based on observation review the facility failed comprehensive care	is not met as evidenced n, interview, and document		A: Side rail use was added to plan for the identified resident. B: All Side rails assessments we reviewed for completion and cruchecked with the care plan on C: Side rail assessment form we modified to add a check/remineradded to the temporary or permitted.	vere ross 10/28/15. vas der and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION G	(X3)	DATE SURVEY COMPLETED	
		245360	B. WING			C 10/20/2015
	ROVIDER OR SUPPLIER	TY OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP COD 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	PE	10/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 279	9/22/2015, indicated required extensive a and activities of dail During the initial factorial p.m., R56 was quarter side rails on on 10/14/2015 at 1: the side rails and "it aid in turning. R56's initial Siderail 09/08/2015 indicate side rails. The facility Side Ratorial on the facility Side Ratorial parts in bed and transibed. Res is alert and Review of R56's cartorial for bed more assessment indicate.	m Data Set (MDS), dated I R56 was cognitively intact, assistance with bed mobility, y living. ility tour on 10/12/2015 at observed to have bilateral his bed. During an interview 45 p.m. R56 stated he used necessary to have rail up" to Assessment completed on d there was no need for the I Assessment form dated d "Therapy request ide rails to assist with sitting iers in out of bed and turning d oriented." The plan, last updated on dentify that R56 utilized any obility, even though R56	F 2'	care plan. D: 10% of residents will be au Side rail use on care plan. The completed by DON or design monthly basis throughout the year with results reported to Council.	his will be ee on a following	
F 282 SS=E	time. The side rails and the nursing ass 483.20(k)(3)(ii) SER PERSONS/PER CA	eviewed with RN-A at this were missing on the care plan istant care sheets for R56. VICES BY QUALIFIED RE PLAN ed or arranged by the facility y qualified persons in	F 2	82		11/30/15

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_			C
		245360	B. WING				20/2015
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC.	TINE LIVING COMMUNIT	TY OF NEW LONDON		10	00 GLEN OAKS DRIVE		
BENEDIC	TIME LIVING COMMONI	TOF NEW LONDON		N	EW LONDON, MN 56273		
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F 282	Continued From page accordance with each care.	e 9 h resident's written plan of	F	282			
	by: Based on observation review, the facility fainthe plan of care for 2 R53) reviewed for act 4 of 4 residents (R17 reviewed for range of residents (R57, R35, ambulation; 2 of 3 residents for pressure ulce (R2) reviewed for moderate for m	f motion (ROM), 3 of 4 R28) reviewed for sidents (R14, and R31) at rs, and for 1 of 3 residents initoring skin concerns. In Data Set (MDS) dated R8 had severe cognitive uired extensive assistance to			Range Of Motion A: The identified residents are being assisted with ROM per care plan. B: All residents that require ROM Servi were reviewed for proper ROM se C: Additional staff has been crossed trained in rehab/ROM to ensure that residents are getting their ROM program per assessment. RN case managers we educated in their responsibility to monif these programs. D: Staffing coordinator to ensure that there is a Rehab aide 5 days a week to complete ROM/rehab. programs. DON designee will audit 10% of documentati for completion of ROM weekly x 4 weel monthly x 3 months, then quarterly throughout the following year with resurreported to Quality Council.	or on or	
	intervention of, "Amb [distance as tolerated [extensive] 2A [assist [with] w/c [wheelchair During observation of at 9:20 a.m. R28 was toileting by nursing at in his wheelchair using started to self propel hallway, when an uniter to self propel hallway.	d 10/9/15, identified an ulate to/from meals DAT d] as he will allow with ext tof two]; follow behind w/ f]." If morning care on 10/14/15, assisted with dressing and ssistant (NA)-C, then seated and a mechanical lift. R28 out of his room into the dentified staff member pushed him down to the			Ambulation A: The identified residents identified are being assisted with ambulation. B: All residents that require staff assist with ambulation were reviewed for propambulation services. C: Staff educated to provide ambulation services to those residents who have been assessed for services. Care shee were updated to include everyone on a ambulation plan and to include staff init and distance. Nurses/ TMAs educated	er 1 ts n ials	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		245360	B. WING _			10/	20/2015	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
BENEDIC	TINE LIVING COMMUNI	TY OF NEW LONDON			0 GLEN OAKS DRIVE			
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F 282	Continued From page 10			282				
	breakfast meal in his attempt to ambulate directed by the care When interviewed or restorative aide (RA) ambulate well using and was supposed to	wheelchair. No offer or R28 was provided as			checking these sheets upon completion shift. D: DON or designee to audit 10% of the care sheets that ambulation is occurring for all residents on ambulation plan weekly x 3 weeks then monthly throughout the following year with resurreported to Quality Council.	e g		
	R53 had moderate c extensive assistance and transferring, and	erly MDS dated 9/16/15, identified oderate cognitive impairment, required essistance for bed mobility, toilet use, rring, and had functional limitations in the office of the oderate constant impairment extremities.			Pressure ulcer A: B: Facility and contracted staff have been educated re: importance of repor refusal of care to the nurse, alerting another staff for re-approach, and following care sheets and repositioning and toileting plans.	ting		
	intervention of, "Staff [bathroom] as he is a wishes with walker a follow." An undated Center-Maple 1 nurs directed staff to, "Am	d 9/16/15, identified an foffer to walk to and from BR able and in halls per his nd w/c [wheelchair] to Glenoaks Care ing assistant care sheet ab [ambulate] to/from meals erated] w/ [with] walker et			C: Agency staff orientation checklist had been updated to include explanation of the care sheets, repositioning and toiler records, and promptly notifying nurse or refusals of repositioning, toileting, and other assistance. D: DON/Designee to audit 10% of repositioning and toileting plan compliance weekly x 4 weeks, biweekly	f iting of		
During an interview on 10/16/15, at 2:35 p.restorative aide (RA)-B stated R53 had a restorative program since 6/17/15 for ambut RA-B stated, "Therapy wanted me to walk He's supposed to walk every day. Sometim doesn't want to walk but will always do his ups." RA-B also stated, "I try to walk him ever day but I get pulled to work on the floor. Wishortage of staffing, it doesn't get done."		-B stated R53 had a since 6/17/15 for ambulation. by wanted me to walk him. allk every day. Sometimes he but will always do his pull ed, "I try to walk him every o work on the floor. With the			for a month then quarterly throughout to following year with results reported to Quality Council. Skin Monitoring A: Bruise on identified resident has healed. B: All residents have had a skin audit completed with bath and all skin			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245360	B. WING _			l	20/2015
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	20/2013
				10	0 GLEN OAKS DRIVE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		NI	EW LONDON, MN 56273		
(X4) ID PREFIX TAG	((EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 282	Continued From page	e 11	F 2	282			
	During an interview or registered nurse (RN Care documentation			conditions have been assessed and addressed.			
	record, and stated, "7	The last time [R53] was nd in the hallway [by nursing			C: Reviewed with Staff the importance immediately reporting skin changes to nurse.	of	
	revised 9/2/2015, inc disease, hemiplegia a annual MDS, dated 8 required extensive as including bed mobility indicated R17 was constituted R17's care plan, upda mobility as a care are nursing program. R1 "exercise group," " Rupper and lower extra "monitor for change"	ated 9/2/2015, identified ea, and directed a restorative 7's program included an OM (range of motion)" to emities, and direction to in ability to participate in changes in assist with			D: Documentation for all residents with wounds, wound forms, and proper wou documentation and interventions will be audited by DON or designee weekly x weeks then biweekly for one month the quarterly throughout the following year with results reported to Quality Council	ind e 4 en	
	registered nurse (RN managers" were in cl programs, that they r and "should be monit programs "are getting she "did not know" if done consistently. R primary restorative ail leaving the facility, rig someone who wants	narge of the restorative eviewed "their own resident" foring progress, as well if the g done or note." RN-A said the programs were getting N-A stated there was one de, and her back up is ght now have" not found					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP IDENTIFICATION NUMBER: A. BUILDING			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245360	B. WING _			1	20/2015
	ROVIDER OR SUPPLIER	Y OF NEW LONDON		10	REET ADDRESS, CITY, STATE, ZIP CODE O GLEN OAKS DRIVE EW LONDON, MN 56273	1 10/	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 282	see R17 "three times program, which include extremities. RA-B ac consistently receiving	B stated she is supposed to a week" for his restorative ded his upper and lower knowledged R17 was not	f 2	282			
	7/22/15, identified R2 required extensive as mobility and transferr limitations in range of impairment to upper a R24's care plan, date	4 had intact cognition, sistance of two staff for bed ing, and had functional motion (ROM) with bilateral and lower extremities. d 10/11/15, identified R24					
	contractures to all exidiagnosis, and includ ability to bear weight himself. R24's care p massage to neck price passive range of mot extremity, active assitive (AAROM) to right upp	ed a goal to maintain the for transfers and to feed lan included providing or to starting range of motion, ion (PROM) to left upper stive range of motion oer extremity, and bilateral ises with weights, knee					
	· ·	wisheets dated tified R24's restorative ocumented as completed as					
	> August 2015 > September 2015 > October 2015	0 of 14 opportunities 6 of 13 opportunities 5 of 13 opportunities 1 of 8 opportunities					
		n 10/16/15, at 7:59 a.m., [RA)-A stated R24 was					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245360	B. WING _			1	C 20/2015	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273		AKS DRIVE	1 10/	20/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
F 282	scheduled to receive times a week, but this RA-A stated, "We har and more to work the to this [restorative proto do the best we car tough. We are pretty staff were trained to so other staff did not residents. RA-A state when their exercises and stated he had re director of nursing (DR3's annual Minimum 9/19/15, identified R3 impairment, required staff for bed mobility, staff for transfers. The have bilateral impairment with zero days received R3's care plan dated goal to maintain anklarange of motion (PR0 (toes upward), planta with 15 reps each foo upward and hold 30 seach foot/ankle), up tolerates. Review of R3's Resto 6/1/15 to 10/20/15, ic PROM 25 of 65 oppor frame.	restorative program, three is wasn't always getting done. We been getting pulled more of floor, so we've been getting by	F2	282				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		245360	B. WING			1	20/2015	
	ROVIDER OR SUPPLIER	Y OF NEW LONDON		10	REET ADDRESS, CITY, STATE, ZIP CODE O GLEN OAKS DRIVE EW LONDON, MN 56273	1 10/	20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE	
F 282	are not being consister restorative aides are with cares due to bein typically scheduled to programs four days a pulled away from their The nursing assistant do they complete rest RA-A stated these conthe former director of R29's quarterly Minim 8/29/15, identified R2 memory problems, where the care plan dated "at moderate risk" of "limited" ROM to her the care plan identified up to 3 X [times] were recommendations." Review of the Restoration 8/2015 to 10/15 was to be offered three Restorative Flowsheed received the following > July 2015 > August 2015 > September 2015 > October 2015	are identified on the et. The restorative programs ently completed as the pulled to the floor to helping short staffed. RA-A is o work on restorative week, but is consistently in three of the four days. Its (NA) are not trained, nor torative programs. Further, incerns had been reported to nursing (DON). The Data Set (MDS) dated the phad long and short term as totally dependent on staffed limitations in her ROM on the phad long and short term as totally dependent on staffed limitations in her ROM on the phad long and short term as totally dependent on staffed limitations. Further, and an intervention of, "PROM kly per therapy the later of the programs as week. The et Records identified R29's	F	282				
	restorative aide (RA)-	A stated he had been loor to do cares instead of						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245360	B. WING			C 0/20/2015		
	ROVIDER OR SUPPLIER	ITY OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP COL 100 GLEN OAKS DRIVE NEW LONDON, MN 56273		0/20/2013		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 282	had been getting co Further, only two starestorative programs AMBULATION R57's diagnoses, as orders dated 9/16/2/hemiparesis. The q9/10/2015, indicated assistance with transliving. The MDS als cognition. During observation on nursing assistant (N morning cares. R57 assistive walking deand transfer into his a gait belt to assist In an interview on 10 stated he participate lately he was only g	s, so the restorative programs impleted "less and less." aff were trained to complete is. s identified on physician's 015, included hemiplegia and uarterly MDS, dated if R57 required extensive indicated he had intact on 10/14/2015 at 7:45 a.m. A)-B assisted R57 with a used a hemi walker (an exice) to move from the bed in wheel chair, while NA-B used R57. 0/15/15 at 2:15 p.m., R57 as in a walking program, but etting assistance with walking, wo nursing assistants. R57	F 28					
	Form, dated 6/30/20 ambulate with (R57) assistance of 1 with wheel chair behind. 1-3 times per day.	rative Nursing Communication 015, indicated R57 was to) daily in hallway, using gait belt, and 1 to push the Walk the length of handrail,						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	I \ /	(X3) DATE SURVEY COMPLETED		
		245360	B. WING _			C 10/20/2015	
NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY OF NEW LONDON				STREET ADDRESS, CITY, STATE, ZIP COL 100 GLEN OAKS DRIVE NEW LONDON, MN 56273		10/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 282	In an interview on 1 restorative aide (RA restorative ambulati hallway, and also th about getting his wa "was getting pulled"	0/15 indicated R57 had if 102 opportunities. 0/16/2015 at 8:18 a.m., a)-A stated that R57 had a on program to walk in the at R57 "was pretty persistent sliking done." RA-A stated he to work on the floor, and the swere often missed and not	F2	282			
	updated 10/13/2015 disease, weakness, quarterly Minimum I 6/25/2015, indicated assistance with tran activities of daily livi R35 had intact cogn R35's care plan, upo mobility as a care at to and from meals we	dated 10/13/2015, identified rea, and directed staff to "walk with FWW &1A (4 wheeled 1), pull w/c (wheel chair)					
	R35 was in her whe and NA-G pushed F dining area. NA-G on the name of the name	on 10/19/2015 at 12:05 p.m., el prior to the start of lunch, 235 from her room into the did not offer to ambulate R35. 0/19/2015 at 12:08 p.m., not know R35 was on a on 10/16/2015 at 11:32 a.m.,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	COMPI	(X3) DATE SURVEY COMPLETED C		
		245360	B. WING _			20/2015		
NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY OF NEW LONDON				STREET ADDRESS, CITY, STATE, ZIP (100 GLEN OAKS DRIVE NEW LONDON, MN 56273				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 282	formal restorative per walked from her much as she could always a willing parencouragement, but keep walking. Rawalking was documented anywhous walking program "is that the nursing assistent of the walking and restoration." RN-B walking and restorations walked from the walking and restorations walked from the walking and restorations was a walking was a walking and restorations was a wa	RA)-B stated R35 "had no program," but that she was to program," but that she was to proom to the dining room, as an example as a stated R35 was not recipant, and needed at it was important for her to B was not sure where R35's mented or if the program was mented for R35. 10/19/2015 at 3:01 p.m., RN)-B stated she did not know	F2	282				
	had severe cognitive extensive assistance room or corridor, use and had no episode R28's care plan date ambulate R28 to assistance with extensive assistance During observation 10/14/15, at 9:20 at transfer into his who himself in his wheel hallway. An uniden	dated 8/26/15, indicated R28 //e impairment, and required ce, was unable to walk in the sed a wheelchair for mobility es of rejecting cares. ted 10/9/15, directed staff to nd from meals, as tolerated stance. of personal cares on .m. NA-C assisted R28 to eelchair. R28 then propelled lchair with his feet into the tified staff walking by R28, to the dining room for						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245360	B. WING _			- 1	C / 20/2015	
NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY OF NEW LONDON				100 GLEN O	RESS, CITY, STATE, ZIP CODE AKS DRIVE DON, MN 56273	10	72072010	
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F 282	Continued From pag	ge 18	F2	282				
		accepted. Staff did not offer eal, as identified in his care						
	restorative aide (RA restorative program, walk him as directed	10/16/15, at 11:28 a.m.)-A stated R28 was not on the but staff were directed to I on the care plan. RA-A well with a walker for short						
	stated R28 does not	10/16/15, at 12:01 p.m. NA-G walk, and she was not aware ed to be walking R28.						
	PRESSURE ULCER	2						
	9/8/15, identified R1							
	skin breakdown rela incontinence of uring staff to turn and repo and to provide toilet	ed 9/18/15, identified a risk for ted to pressure, and was e. The care plan directed osition (R14) every two hour, ng on rising, every 1.5 hours two hours at night, and as						
	bed, on her back. For receiving the help for open area on her but	2 p.m. R14 observed lying in 114 stated she was not r repositioning, and had an ittocks. R14 stated the d turning every 1.5 hours, but						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245360	B. WING _			10/2	20/2015
NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY OF NEW LONDON			,	STREET ADDRESS, CITY, STATE, ZIP O 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	ODE	10/-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	FION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 282	she was lucky to get and once at night. During continuous ob 7:01 a.m. to 9:44 a.m her room. R14 was rany toileting or incontinen 10/14/15, at 9:40 a.m (LPN)-C stated R14 swith toileting every tw. When interviewed on LPN-C stated R14 is and offered toileting enot be acceptable to time (9:40 a.m.) with toileted or repositione. On 10/14/15, at 9:44 entered R14's room, right and placed pillow offered to assist in us refused. When interviewed on NA-C stated R14 wou bedpan was used, an should be offered every when interviewed on RN-B stated R14 was bowel and bladder, a and repositioning. R1 acceptable to go two	servation on 10/14/15, from . R14 was laying in bed in not offered or provided with inence cares for 2 hours en notified of the lack of ce care for R14 on . licensed practical nurse should have been assisted to hours. 10/14/15, at 9:40 a.m. to be turned, repositioned, every two hours, and it would go from 7:01 a.m. to current no one offering (R14) to be add. a.m. LPN-C and NA-D assisted R14 to turn to the w under left side. R14 was ing the bathroom but R14 10/14/15, at 1:02 p.m. and be repositioned if the add believed repositioning ery two hours. 10/14/15, at 1:46 p.m. as frequently incontinent of and is to be offered toileting N-B stated it would not be hours and 45 minutes ang or repositioning, and it	F 2	282			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		DNSTRUCTION		PLETED	
		245360	B. WING _			1	C 20/2015	
NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY OF NEW LONDON				STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273			10/20/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 282	Continued From page	e 20	F 2	282				
	severe cognitive impa	dated 9/9/15, indicated airment required extensive obility and was at risk for e ulcer.						
	be at risk for skin imp including alternating in wheelchair, heel be	d 9/21/15, indicated R31 to pairment with interventions air mattress on bed, cushion pots on when in bed, and ow when in bed or recliner.						
	at 6:28 a.m. R31 did	f morning care on 10/15/15, not have a pillow under R3's 9:54 a.m. R31 was in bed, eath the feet.						
	RN-C stated R31 was	10/15/15, at 11:05 a.m. s to have a pillow under the ssist in preventing pressure						
		10/16/15, at 9:58 a.m. unaware R31 should have a e feet when in bed.						
		10/16/15, at 10:02 a.m. as to have a pillow placed in bed.						
	RN-C stated staff we required on the care	10/20/15, at 9:34 a.m. re informed of the cares sheets, and in the for R31 to have pillows						
		10/20/15, at 9:40 a.m. v had been placed under						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	IPLE CONSTRUCTION NG	_	(X3) DATE SURVEY COMPLETED
		245360	B. WING _			C 10/20/2015
NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY OF NEW LONDON				STREET ADDRESS, CITY, 100 GLEN OAKS DRIVE NEW LONDON, MN 5		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORI	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA DEFICIENCY)	
F 282	breakfast, and indica	ne 21 was assisted to bed after ated she was not aware this	Fí	282		
	was required. SKIN MONITORING	i e				
	change Minimum Da included long term (dentified on the significant ata Set (MDS), dated 9/1/15, current) use of was severely cognitively				
	focus and included, to] Coumadin usage thin and fragile and a bumping into things The care plan direct [with]/daily cares and for bruising r/t Coum	d 9/14/15, identified skin as a "At risk for bruising r/t [related . Easily bruises and skin is gets skin tears easily r/t with her w/c [wheelchair]." ed staff to, "Monitor skin w d wkly [weekly] bath. Monitor adin use. Monitor for nd refer to MD PRN" [as				
	On 10/14/15, at 7:55 dining room. The to and blue in color wit	a.m. R2 was observed to top of her left hand. a.m. R2 was observed in the p of R2's left hand was black a bruise extending from her approximately 2.5 inches x				
	stated she was not s on the top of her left "bumped into somet	on 10/14/15, at 8:26 a.m. R2 sure how she got the bruise hand. She may have hing." R2 knew she was on a gid this was why she bruised				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245360	B. WING _			10/2	20/2015	
	ROVIDER OR SUPPLIER	Y OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP COD 100 GLEN OAKS DRIVE NEW LONDON, MN 56273)E			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIA		(X5) COMPLETION DATE	
F 282	nursing assistant (NA bruise on R2's hand of when she came to wo did not tell anyone" as was already reported. During interview on 1 stated she saw the bra.m. on 10/12/15, als NA-H said she asked from, but R2 did not refrom. NA-H also said to anyone." When interviewed on licensed practical nur "not aware" R2 had a hand. LPN-B also stated "yesterday" (10/13/15) bruise on top of R2's also said "no one had and the "should have would measure the betteratment sheet to mot A progress note dated indicated R2's bruise bruise was noted on the weekend, when aske stated, 'I bump my had a was already to the stated of the work of the same tell the s	10/14/15, at 9:15 a.m. a-G) stated she saw the con the morning of 10/12/15 ork. NA-G further stated, "I and "assumed" R2's bruise 0/14/15, at 9:17 a.m. NA-H ruise on R2's hand at 6:00 or when NA-H came to work. R2 what the bruise was ecall where the bruise came I, "I did not report the bruise 10/14/15, at 9:28 a.m. se (LPN)-B stated, she was bruise on the top of her left ated she took care of R2 is), too, but did not see the hand. In addition, LPN-B I reported" the bruise to me I." LPN-B then stated she ruise and place on the	F 2					
	turn yellow around the [every] day." Review of the Facility	e edges. Will monitor q policies titled Care Planning m revision date 9/13, and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED	
		245360	B. WING		C 10/20/2015
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	,
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		00 GLEN OAKS DRIVE	
				NEW LONDON, MN 56273	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 282	Continued From page	e 23	F 282		
		hensive revision date 9/10, mentation of the care plan.			
F 309	483.25 PROVIDE CA	·	F 309		11/30/15
SS=D	HIGHEST WELL BEI				11/00/10
	Each resident must re	eceive and the facility must			
		y care and services to attain			
	mental, and psychoso	st practicable physical,			
		comprehensive assessment			
	and plan of care.				
	by: Based on observation review, the facility fail bruising for 1 of 1 residentified at risk of ble medication regime. Findings include: R2's significant changed dated 9/1/15, identified impairment, and had anticoagulant medical R2's care plan dated "At risk for bruising r/flusage. Easily bruises and gets skin tears eas with her w/c [wheelch staff to, "Monitor skin [weekly] bath. Monitor	ge Minimum Data Set (MDS) and R2 had severe cognitive long term use of tion (used to thin the blood). 9/14/15, identified R2 was, a [related to] Coumadin as and skin is thin and fragile asily r/t bumping into things air]." The care plan directed w [with]/daily cares and wkly for for bruising r/t Coumadin bicious lesions and refer to		A: Bruise on identified resident was healed on 11/4/15. B: All residents have had a skin audit completed with bath and all skin conditions have been assessed and addressed. C: It was reviewed with nursing to follo the policies and procedures r/t skin impairment. Policies and procedures r skin issues were reviewed and implemented. It was reviewed with CN and bath aides on immediate notification of nurse when finding a skin issue. Reviewed with CNAs the information to report to a nurse. D: Documentation for all residents with wounds, wound forms, and proper would documentation and interventions will be audited by DON or designee weekly x weeks then biweekly for one month the monthly throughout the following year results reported to Quality Council.	As on O O O O O O O O O O O O O O O O O O

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		245360	B. WING _			C 10/20/2015
	ROVIDER OR SUPPLIER	TY OF NEW LONDON		STREET ADDRESS, CITY, STATE, 2 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	ZIP CODE	10/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED		
F 309	dining room. The top and blue in color. The her knuckles to the vinches x 5 inches. During an interview of stated she was not so on the top of her left have "bumped into sthinner, and this was Review of the medic physician orders dat was prescribed count prevent strokes by the monitored with a labiliternational normalian R2's fax communicated 8/5/15, identified R2's but her most recent twice the INR goal for wrote an order, "Adjuted Vitamin K [medication thinning effects from [milligrams] p.o. [by with the most revent strokes have the INR goal for wrote an order, "Adjuted thinning effects from [milligrams] p.o. [by with the most revent strokes from [milligrams] p.o. [by with the most revent strokes from [milligrams] p.o. [by with the most revent strokes from [milligrams] p.o. [by with the milligrams] p.o	a.m. R2 was observed in the of R2's left hand was black he bruising extended from wrist, approximately 2.5 on 10/14/15, at 8:26 a.m. R2 ure how she got the bruise hand. She stated she may omething," was on a blood why she bruised "easily." all record identified R2's ed 10/14/15, identified R2 hadin, a medication to hinning the blood which is oratory value called an zed ratio (INR). tion from the physician dated is INR goal was "2.0 - 3.0", walue was "7.9", more than or R2. Further, the physician lust coumadin to: Hold 8/5/15; in used to reverse the blood coumadin] 2.5 mg mouth] today." 10/14/15, at 9:15 a.m. A-G) stated she saw the on the morning of 10/12/15 he came to work. NA-G	F3	309		
	"assumed" R2's brui being monitored. During interview on	se was already reported and 10/14/15, at 9:17 a.m. NA-H he bruise on R2's hand at				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245360	B. WING _			C 10/20/2015	
	ROVIDER OR SUPPLIER	Y OF NEW LONDON		STREET ADDRESS, CITY, STATE, 2 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	ZIP CODE	10/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIAT HENCY)	(X5) COMPLETION DATE	
F 309	the bruise came from the nurses, "I did not when interviewed on licensed practical nur "not aware" R2 had a hand. LPN-B took ca (10/13/15), but did not R2's hand. LPN-B state bruise to her, and assistants noted the bruise to her, and assistants noted the bruise. It would begin monitorin 10/14/15. R2's medical record in communication fax da R2's INR (internationary range was 2.0 to 3.0; 10/14/15. The physical doses of coumadir INR on 10/16/15. During interview on 1 registered nurse (RN) "are expected" to repon duty. All NA's record for Resident Cares) withem to report bruisin condition, "My expect assistants would report observed." RN-A state been monitored, and need to contact the promptly to ensure the	5. R2 did not recall where nor did NA-H report it to report the bruise to anyone." 10/14/15, at 9:28 a.m. se (LPN)-B stated, she was bruise on the top of her left re of R2 "yesterday" to see the bruise on top of ated "no one had reported" if any of the nursing bruise, they "should have" Further, LPN-B stated she and the bruise that day, on the dentified a physician ated 10/14/15, identified all normalized ratio) goal and her INR was 5.7 on the identified orders to hold a for R2 and recheck her 10/16/15, at 7:56 a.m. 10-A said nursing assistants fort new bruises to the nurse ever training (Expectations with orientation which tells g and changes in skin	F3	309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	(X3	3) DATE SURVEY COMPLETED
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		245360	B. WING _			10/20/2015
	ROVIDER OR SUPPLIER FINE LIVING COMMUNIT	Y OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)		OULD BE	(X5) COMPLETION DATE
F 309	of high INR levels, the monitoring R2's bruis remained in therapeur. An undated Expectat Nursing Assistant Car Demonstrated Appropriate Demonstrate Demo	coumadin, and had a history e facility was not consistently ing to ensure her INR levels tic range for R2. cons for Resident Cares: re Delivery Practice oriate Care training 'Changes in resident d to licensed nurse, including ranges in skin condition."		311		11/30/15
	by: Based on observation review, the facility fail consistently impleme improve and/or maint abilities for 4 of 5 resing R53) in the sample renursing services. Findings include: R57's diagnoses, as orders dated 9/16/20 hemorrhage, hemiple quarterly MDS, dated required extensive as	n, interview and document ed to provide and nt ambulation services to ain residents' ambulation dents (R57, R35, R28 and eviewed for restorative		A: the identified residents are be assisted with ambulation. B: All residents that require staff with ambulation were reviewed for ambulation services. C: Staff educated to provide ambuservices to those residents who have been assessed for services. Care were updated to include everyon ambulation plan and to include stand distance. Nurses/ TMAs educhecking these sheets upon comshift. D: DON or designee to audit 10% care sheets that ambulation is of for all residents on ambulation plan weekly x 3 weeks then monthly	assist or proper oulation have e sheets e on an taff initials acated on apletion of	S

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		LETED
		245360	B. WING _			1	20/2015
	ROVIDER OR SUPPLIER	Y OF NEW LONDON		10	TREET ADDRESS, CITY, STATE, ZIP CODE 00 GLEN OAKS DRIVE EW LONDON, MN 56273	1 1077	20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SH			(X5) COMPLETION DATE
F 311	care area assessment status/rehabilitation prindicated R57 require and was walking with During observation or nursing assistant (NA morning cares. R57 assistive walking devand transfer into his varied agait belt to assist Rillian interview on 10/stated he participates lately he was only gellonce a day," with two stated the walks "do not weekend." A Therapy to Restora Form, dated 6/30/201 ambulate with (R57) assistance of 1 with gowheel chair behind. A PT (physical therap Discharge summary, R57 had received skit training and neuromulimproved R57's abilitit transfer and ambulati included "continue warnursing and perform I maintenance program maintenance program."	e had intact cognition. A at (CAA) for functional otential, dated 6/15/2015, and assistance with all ADLs, therapy. In 10/14/2015 at 7:45 a.m. In 10/14/2015 at 7:45 a.m	F	311	throughout the following year with resurreported to Quality Council.	Its	

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245360	B. WING				C
	ROVIDER OR SUPPLIER			100	EET ADDRESS, CITY, STATE, ZIP CODE GLEN OAKS DRIVE V LONDON, MN 56273	1 10	/20/2015
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 311	documented) August 12 September 3 October 2 In an interview on 10 restorative aide (RA restorative ambulation hallway, and also the about getting his wa program was missed more than was documented had not declined in he walking days were not and more he "was getfloor, it seemed "about stated lately it was "the residents' program was scheduled for residents' program was scheduled for residents' program, he would a coccupational therapy sure who was in chaprogram at the facility. In an interview on 10 registered nurse (RM managers" were in coprograms, that they and "should be mon programs "are getting she "did not know" if done consistently. Firmary restorative as	ation services: B1 opportunities (no refusals) B2 of 31 opportunities of 30 opportunities of 10 opportunities D/16/2015 at 8:18 a.m., D-A stated that R57 had a con program to walk in the at R57 "was pretty persistent liking done." RA-A said R57's d, but said it was completed mented. RA-A stated R57 nis ability, even though some nissed. RA-A stated more etting pulled" to work on the but 50% of the time." RA-A pretty frustrating" not getting ams done, even though he ehab more frequently. RA-A programs were often missed on the weekends. RA-A stated about a residents restorative ask the physical or y department but was not arge of the restorative	F	311			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 311	Continued From pagesomeone who wants		F 3	11			
	updated 10/13/2015 disease, weakness, quarterly Minimum I 6/25/2015, indicated assistance with tran living. The MDS als cognition. The CAA Status/Rehabilitation indicated she had a mobility and increas	i, included Parkinson's and history of falling. The Data Set (MDS), dated I R35 required extensive sferring, and activities of daily o indicated R35 had intact for ADLs Functional n Potential, dated 3/25/2015, n acute decline in ADLs and ed weakness related to a e CAA also indicated R35 ich impacted her					
	dated 5/17/2015, inc therapy from 3/19/2/ indicated R57 "ha activity tolerance an which allowed for in and improved transf discharge plan inclu	gress & Discharge summary, dicated R35 received physical D15 to 5/17/2015. The report is shown gains in strength, dineuromuscular function creased distances walking fers and ambulation." The ded "Recommendation ent and/or caregivers include program."					
	assistant care sheet "walk [R57] to and fi (three times a day) a In an interview on 10 stated R35 "had no but that she was to	ks Care Center - Oak nursing printed 10/16/2015, directed from DR (dining room) TID as tolerated." 0/16/2015 at 11:32 a.m., RA-B formal restorative program," be walked from her room to much as she could. RA-B					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	TY OF NEW LONDON		100	REET ADDRESS, CITY, STATE, ZIP CODE OGLEN OAKS DRIVE W LONDON, MN 56273	1 10.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 311	Continued From pag		F:	311				
	important for her to k	gement, but that is was eep walking. RA-B was not llking was documented.						
	stated during cares signed that yesterday." "sometimes refuses asked me to walk "for she walked more a consummer they would to R35 also said her fee "and my balance is consumed by the start of lunch, and Naroom into the dining ambulate R35.	to walk," but the staff has not r a long time." R35 also said ouple months ago, "in ake me," but not of late. et hurt when she walked,						
	NA-G said she "did r walking program.	ot know" R35 was on a /19/2015 at 3:08 p.m., NA-N						
	stated R57 "has not room this past week. afternoon shift, he ha and the past couple and instead would ra	walked down the the dining " NA-N stated during his as asked R57 to ambulate, of times "she has refused," ther be pushed in her wheel e was not aware if R57 was						
	registered nurse (RN whether R35's walkir documented anywher recent care conferen	/19/2015 at 3:01 p.m.,)-B stated she did not know ng program "was re." RN-B said since most ce, R35 expressed her legs nd was refusing more to						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		INSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245360	B. WING _			1	20/2015
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 311	on the CNA care she assistants "are supported added that "right now programs were not go "probably were not result in an interview on 10 stated R35 "was able take her." NA-O stated to record ambure corded distances "or said the sheets were "but I have not seen in NA-O said she "did now aware of this. NA-O concern before, when walked, or their restor would get reminders, then kinda goes by the [walking] is the care seen sexpected that we do thought the real issues help." In an interview on 10 physical therapist (Pohave a stronger follow are discharged from the past, "we had a week charge of the resident."	ed her walking program "is et", and that the nursing osed to document." RN-B of the walking and restorative etting monitored, and ecorded." //19/2015 at 3:12 p.m., NA-O et to walk, if people would ed the nursing assistants lation in a book, but now on the aide sheets." NA-O to be turned in every day, them get turned in lately." the said the facility had this re residents did not get rative programs, then staff "and it improved for a while, he wayside." NA-O also said sheets, "and it would be it." NA-O also said sheets, "and it would be it." NA-O also said sheets was time, and not enough (/20/2015 at 9:18 a.m., the F) stated the facility "should of w up program after residents therapy. The PT said in the kly meeting with the RN in the and the rehab aid" and		311	DEFICIENCY)		
	monthly, and it "did n was getting therapy of or walking program." for us to "catch things functionality. The PT "were not" consistent	d be discussed" at least of matter" whether a resident or was on a range of motion. The PT said it was a way so before a resident lost said restorative programs cly completed and it was ain qualified staff, but "we					

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		245360	B. WING _			1	20/2015
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 311	Continued From page still have to take care		F:	311			
	had severe cognitive extensive assistance and toileting. The ME no episodes of rejecti	impairment, and required of two staff for transferring OS further indicated R28 had ng cares, did not walk in the g the assessment period,					
		I 10/9/15, directed staff to from meals, as tolerated ince.					
	dated 8/21/15, identifi included, "[R28] will a staff 100 feet safely w	vsical Therapy Plan of Care ed a long term goal which mbulate daily with nursing vith front wheeled walker sist on even surfaces."					
	mechanical lift to tran R28 then propelled hi his feet into the hallwa walking by R28's roor	personal cares on NA-C assisted R28 using a sfer into his wheelchair. mself in his wheelchair with ay. An unidentified staff m, offered to push him to the fast, which he accepted.					
	restorative aide (RA)- restorative program, t walk him as directed of	0/16/15, at 11:28 a.m. A stated R28 was not on the out staff were directed to on the care plan. RA-A ell with a walker for short					
	information coordinate	0/16/15, at 11:38 a.m. health or (HIC)-A stated R28 had facility three times in the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245360	B. WING _			C 10/20/2015
	ROVIDER OR SUPPLIER	TY OF NEW LONDON	•	STREET ADDRESS, CITY, STATE, ZIP CODI 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	-	10/20/20 10
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 311	F 311 Continued From page 33 past, and would transfer himself into the recliner.		F	311		
	HIC-A stated R28 do	oes not ambulate as much pels himself in the wheelchair				
	stated R28 does not	10/16/15, at 12:01 p.m. NA-G walk, and she was not aware ed to be walking R28.				
	stated the former RN restorative nursing of hospitalization on 8/ working with therapy to see what therapy stated she was not a Therapy Plan of Car	10/16/15, at 12:14 p.m. HIC-A I case manager placed R28's in hold after his most recent 17/15, because he was if at the time, and was waiting recommended. HIC-A aware of the new Physical e dated 8/21/15, which ulate the resident daily with it.				
	stated physical thera to nursing on 8/21/1 return, to walk with s unable to find any co	10/16/15, at 1:14 p.m. PT-A apy made a recommendation 5, after R28's last hospital staff daily 100 feet. PT-A was ommunication of this direction d it must had gotten missed.				
	assisted R28 to walk stated R28 did not h and would ensure no	roximate 1:20 p.m. PT-A c approximately 90 feet. PT-A ave a decline in ambulation, ursing was aware of the lk R28 daily to maintain ibility.				
	R53 had moderate of	dated 9/16/15, identified sognitive impairment, required of one for transferring, and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245360	B. WING _			C 10/20/2015
	ROVIDER OR SUPPLIER	TY OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP CO 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 311	the MDS identified R behavior or rejection During an observation R53 was lying in bed blankets over head. I rolled slightly onto hi R53's Care Area Assidentified, "Res [residuagnoses: hemipare and HX [history] of h Requires ext [extens	wice with extensive m and corridor. In addition, 53 had no displays of of cares. In on 10/13/15, at 3:47 p.m., l, on the left side, with his When approached, R53 is back, with both knees bent. Ressment, dated 6/11/15, dent] at risk r/t [related to] esis (LEFT), TIA, DM, PVD, amstring contractures. ive] assist with bed mobility,	F:	311		
	functional ROM to (Bextremities]. He does contractures. Curren (occupational therap ambulate and stand A review of a progres identified R53 had be on 6/16/15, and, "The restorative. Recomm to meals as tolerated feet and lower legs of to facilitate mobility. I ambulate to meals we ambulation program sit to stand at bar to to] contractures." R53's care plan, date offer to walk to and fi	s have (B) hamstring tly working with OT y) to regain some ability to better." ss note, dated 6/17/15, een discharged from therapy erapy recommends endations include ambulate I to stretch hamstrings with on bolster for several minutes Resident is on the list to ith staff. Will place on with restorative as well and stretch hamstrings d/t [due				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245360	B. WING		C 10/20/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	10/20/2015	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION	
F 311	A review of the Glen nursing assistant car staff to, "Amb [ambu [distance as tolerate w/c." Review of R53's The Communication Form R53's goals to work standing, and mobilito meals as tolerated feet and lower legs of to facilitate mobility participate as much Review of the Resto 6/17/15 -10/19/15, in program had been compared by the concerned because [mechanical lift] sling He's supposed to be understaffed." FM-A become more contral and stretching his le	oaks Care Center-Maple 1 re sheet, undated, directed late] to/from meals DAT d] w/ [with] walker et [and] erapy to Restorative Nursing m, dated 6/16/15, indicated towards, were transfers, ty, and included, "Ambulate d. Can stretch hamstrings w/ on bolster for several minutes .Encourage Pt [patient] to as possible." rative Flowsheets from indicated the ambulation ompleted as follows: of 13 opportunities of 31 opportunities with 2 of 31 opportunities with 3 of 30 opportunities with 1 of 19 opportunities with 2 on 10/16/15, at 2:11 p.m., or (FM)-A stated, "I'm there was a Hoyer g in [R53's] recliner today. E walked. They are so stated R53 had potential to actured if staff weren't walking	F 31			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
	245360	B. WING _			C 10/20/2015	
NAME OF PROVIDER OR SUPPLIEF BENEDICTINE LIVING COMM			STREET ADDRESS, CITY, STATE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273		10/20/2013	
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			
restorative progra RA-B stated, "Th He's supposed to doesn't want to w ups." RA-B also s day but I get pullo shortage of staffii During an intervice certified occupati stated, "When we therapy and reco becomes a nursii the nursing staffi restorative progra Interdisciplinary T physical therapis During an intervice registered nurse Care documentar record, and state walked in his roo assistants] was of Facility policy title revision date 10/ be recorded in th - the date and tin performed - the name and ti performed the pro- the type of rang - whether the exe- how long the exe- Reporting	RA)-B stated R53 had a am since 6/17/15 for ambulation. erapy wanted me to walk him. walk every day. Sometimes he walk but will always do his pull stated, "I try to walk him every ed to work on the floor. With the ing, it doesn't get done." Ew on 10/16/15, at 3:05 p.m., conal therapy assistant (COTA) edischarge a resident from ammend restorative nursing, that ing program." She would expect to monitor residents receiving am and discuss concerns at the Team (IDT) meetings, which the it and COTA attended. Ew on 10/19/15, at 11:59 a.m., (RN)-A reviewed the Point of tion in R53's electronic medical id, "The last time [R53] was m and in the hallway [by nursing on 9/14/15." The Range of Motion Exercises and identified the following should be resident's medical record: the that the exercises were	F	311			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	IPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		245360	B. WING _			C 10/20/2015
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F 311 F 312 SS=E	facility policy and pro- practice 483.25(a)(3) ADL CA DEPENDENT RESID A resident who is una daily living receives the	nplaints made by the exprocedure resident's ability to redure end the treatment, the expression in accordance with ressional standards of the treatment of the	F3			11/30/15
	by: Based on observation review the facility failed assistance for 6 of 7 in R33, R47 and R24), with staff for bathing. Findings include: BATHING: R17's annual Minimum 8/24/2015, indicated in required extensive as activities of daily living	is not met as evidenced n, interview and document ed to provide bathing residents (R17, R35, R57, who were dependent upon m Data Set (MDS) dated R17 had intact cognition, sistance to complete his g (ADLs), including bathing.		A, B: Bathing of all residents completed per resident prefer C: Bath schedule was modified documentation that baths are completed. Staffing hours have adjusted to ensure that all bat completed per resident prefer Additional staff has been cross baths to ensure bathing schedule. D: The bath schedule will be reweekly for bath completion by Designee x 6 weeks or until scompliance is achieved, then two months, then quarterly the following year with results rep	ences. Indicate to include being we been this are being ence. In the strained in dules are monitored and pool or ustained monthly x roughout the	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	Y OF NEW LONDON		10	TREET ADDRESS, CITY, STATE, ZIP CODE 10 GLEN OAKS DRIVE EW LONDON, MN 56273	1 10/	20/2013	
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F 312	R17 was seated in a dining room, wearing combed, but was unsured in an interview on 10 stated "you just don't you're supposed to," show up for work." Four bath "yesterday" and today, "but it didn't happen "often, too of shaved because shabath, adding, "It both a bath." Further, R13 get a bath tomorrow, on Friday, day after the shaved until Friday." A facility Bath Schedindicated R17 had his on Tuesdays and Frid R17's bathing docum 16, 2015 indicated he during that time, on 1 did not indicate if R13 opportunities. Review of the facility 10/06/15, and on 10/0 R17 was provided a grievance was filed. In interview on 10/16	wheel chair in the main glasses, his hair was shaven. //14/2015, at 1:44 p.m. R17 get baths regularly like adding "the people don't k17 was supposed to have a was hoping to get one appen", and this seems to ten." R17 stated he was not ving goes along with the ers me more that I didn't get a stated he doubted he could "but I bet I'll get a bath first pmorrow. I may not get ulle AM dated 9/21/2015, is whirlpool baths scheduled	F3	312	Quality Council.			
	"by way of the aide d that "every once in a	ocumentation." RN-C said while" the bath aide gets nen we are short," but added,						

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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
F 312	Further, RN-C stated had a more recent be R35's quarterly MDS she had intact cogni assistance with transactivities of daily living During an interview R35 stated that bath had staff tell her "the "there is no one to disuppose to be bathed bathed once a week was "eight days" bet keep postponing my A facility Resident C dated 3/18/2015, inca week and preferre breakfast Tuesday 8 signed by R35. A facility Bath Schedindicated R35 had with Tuesdays and Friday In an interview on 10	w how often that happens." d she "could not state" R17 ath since 10/6. 6 dated 6/25/2015, indicated tion, and required extensive sferring, bathing and most ng. on 10/14/2015, at 9:41 a.m. ling "doesn't happen." She ey are going to do it," then o it." R35 said she was ed twice a week, "and I get ." R35 stated last week it tween baths adding, "They bath." hoices for Bathing document dicated R35 wanted two baths d the time of "morning, after that Thursday." The form was dule AM dated 9/21/2015, whirlpool bath scheduled on	F	312				
	frequency." RN-C somethind in getting results. R57's quarterly MDS R57 had intact cogn	erence sheet, including aid "I do know we have been sidents their bath. 6, dated 9/10/2015, indicated ition, and required extensive sferring, bathing and most						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	T ' '			COMPLETED		
		245360	B. WING			l	C 20/2015	
	ROVIDER OR SUPPLIER	I		10	TREET ADDRESS, CITY, STATE, ZIP CODE OG GLEN OAKS DRIVE EW LONDON, MN 56273	1 10/	20/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 312	activities of daily livin During observation o nursing assistant (NA morning cares, when going to get my show there right now?" NA room was busy, and transfer into his whee told R57 he would ge morning, before breat In an interview on 10 stated R57 did not remorning. NA-A said was last bathed. A facility Resident Ch dated 3/12/2015, india week, on any day, The form was signed member. In an interview on 10 said "that was the first Wednesday morning supposed to be bather Friday, and he "did now R57 said he could now has gone "more than R57 said of all the thid days are very importation." R33's quarterly MDS R33 had moderate of	n 10/14/2015, at 8:10 a.m. A)-C was assisting R57 with R57 asked, "When am I ver? Is there someone in A-C told R57 the shower then assisted R57 with a el chair. At 8:17 a.m., NA-C at a shower later this kfast. A14/2015 at 8:30 a.m., NA-A ceive a bath from her this she did not know when he are later this kfast. A14/2015 at 2:12 p.m., R57 at shower I got this week, on "R57 said he was and had no preferred time." R57 said he was and Monday, Wednesday and ot have a bath on Monday. At remember when, but he one week between baths. Ings that go on here, "bath	F	312				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245360	B. WING _			C 10/20/2015	
	OVIDER OR SUPPLIER	TY OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273		10/20/20 10	
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F 312	stated she would like once a week," but she more than once a week have a whole lot of the is always "Hurry up, when assisting with the A facility Resident C dated 2/11/2015, income a week, one on Tuest A review of R33's baself 1/2015 to 10/16/20 on the following dates 9/8, 9/15, 9/23 and not indicate if R33 hopportunities. In an interview on 10 did not know how of if she got more than identified in the recomposition of the polysical as the property of the property of the work of the property of the property of the work of the w	2/19/2015, at 2:28 p.m. R33 ed to be bathed "more than he has "never been bathed" eek. R33 stated staff don't ime, and feels the interaction hurry up, let's get it done," cares. hoices for Bathing document dicated R33 wanted two baths sday, and was signed by R33. Athing documentation from 2015 indicated she was bathed es: 8/4, 8/11, 8/18, 8/25, 9/1, 10/6. The documentation did ad refused any bathing 20/14/2015 at NA-I stated she ten R33 was to be bathed, or one bath every week as ord. 35 dated 9/10/15, indicated cognitive impairment, and sistance with bathing. 20 on 10/14/15, at 7:10 a.m. R47 are on Mondays and Fridays. Thasn't had a bath in quite a know it has been several bath. 36 dated AM document dated 47 had whirlpool baths	F3	12			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245360	B. WING_		1	C 0/20/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273		3/20/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 312	October 1 - 16, 2015 only two baths during 10/14/15. The docum R47 had refused any In an interview on 10/ assistant (NA)-D state Monday and Fridays. last bath was Friday (NA-D stated R47 did (October 12, 2015) be "short-staffed" and did available. During interview on 10/ stated, "staffing is an not get done" like the further stated, I often residents "are not get R24's annual MDS da had intact cognition, a assistance with most including transferring. During an interview on stated he was "support Monday and Thursdaright away in the mort dressed twice." Furth consistently get his bastaffed", and added his today (10/12/15). On	indicated R47 had received that time, on 10/9/15 and nentation did not indicate if bathing opportunities. 14/15, at 7:16 a.m. nursing ed R47's bath days are on NA-D further stated R47's October 9, 2015). Further, not get his bath on Monday ecause we were d not have a bath aide 0/14/15, at 1:16 p.m. NA-I issue," big time, "baths do y are suppose to. NA-I go home and cry that our ting the care they deserve." ated 7/22/15, indicated R24 and required extensive activities of daily living, and bathing.	F3	312			
	given a bath. During observation of	morning cares on 10/14/15,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245360	B. WING _			1	20/2015
	ROVIDER OR SUPPLIER	TY OF NEW LONDON		100	EET ADDRESS, CITY, STATE, ZIP CODE GLEN OAKS DRIVE W LONDON, MN 56273	1 10/	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
F 312	at 7:54 a.m. NA-A as was, to which R24 re to be Monday [10/12 did not respond, and ready for the day. At still had not had a bat A Resident Choices I 7/2/14, indicated R22 week, in the morning document dated 9/21 whirlpool bath sched Thursday. R24's bathing docum 10/1/15-10/19/15, incompanies bath on 10/1/15, 10/5 R24 did not receive a 10/19/15. During an interview on 10 licensed practical numer charge nurse was to "every once in a whill stated one bath aide and that the bath aid her schedule, trying the said the frequency of facility "has declined." When interviewed on director of nursing (Divere currently off words.	ked R24 when his bath day sponded, "It was supposed (15], but I didn't get it." NA-A completed getting R24 (13:15 p.m., R24 stated he th. For Bathing document dated would like two baths in a late and I would like two baths in a late and I would like two baths in a late and I would like two baths in a late and I would like two baths in a late and I would like two baths in a late and I would like two baths in a late and I would like two baths in a late and I would like two baths in a late and I would like two baths and I would like two bath and I would like two baths." I would like two baths and I would like two bath and I would l	F	312			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245360	B. WING _			l	C 20/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	10/	20/2010
DENEDIO:	FINE LIVING COMMUNIT	CV OF NEW LONDON		10	00 GLEN OAKS DRIVE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		N	EW LONDON, MN 56273		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 314 SS=G	483.25(c) TREATME PREVENT/HEAL PR Based on the compreresident, the facility of who enters the facility does not develop preindividual's clinical control they were unavoidab pressure sores receives ervices to promote the prevent new sores from the facility fair implement and/or repressure ulcers from the healing of current prefersidents (R53, R14) ulcers. This resulted had recurring, multiple Findings include: R53 sustained harm stage 3 (Full thickness fat may be visible but not exposed. Slough obscure the depth of	ehensive assessment of a must ensure that a resident y without pressure sores saure sores unless the ondition demonstrates that le; and a resident having wes necessary treatment and healing, prevent infection and om developing. T is not met as evidenced on, interview, and document led to monitor, assess, and wise interventions to prevent developing, and to ensure essure ulcers for 2 of 2 reviewed for pressure in actual harm for F53 who he pressure ulcers. When he developed two set issue loss. Subcutaneous is bone, tendon or muscle is may be present but does not tissue loss. May include		314	A: R14 and R53 were reviewed by Dietitian, WOC, and nursing to assure proper interventions in place for ulcer treatment/prevention such as dietary supplement, change in wound orders a change in support surfaces. B: All residents have been assessed fo pressure ulcer risk. Residents with a Braden score of 14 or below have had interventions reviewed to ensure adequate prevention of avoidable skin breakdown. All residents were reviewed for proper interventions r/t risk assessment and baseline skin observations completed. C: Case managers educated on following the state of	nd r d	11/30/15
	left and right heel, an loss of dermis preser with a red pink wound pressure ulcer to the monitor and compreh ulcers as they develo	eling) pressure ulcers to the d a stage 2 (partial thickness ating as a shallow open ulcer d bed, without slough) coccyx. The facility failed to pensively assess pressure uped; failed to notify the elopment of pressure ulcers			the pressure ulcer policy and procedure All nurses educated on the use of the pressure ulcer wound sheets to ensure aspects of the ulcer are addressed. LPI charge position created to assist the camanagers in redistribution of workload ensure assessments of wounds are completed. It was reviewed with	all N ise	

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		245360	B. WING			1	20/2015
	ROVIDER OR SUPPLIER			10	TREET ADDRESS, CITY, STATE, ZIP CODE OO GLEN OAKS DRIVE IEW LONDON, MN 56273	1 10/	20/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)			(X5) COMPLETION DATE
F 314	to assure proper trear physician direction of physician when changed the pressure ulcers assessment of the pressure ulcers assess the cause of edeveloped; failed to expressure ulcer treatm care planned intervers. R53's annual Minimu 6/17/15, indicated R5 impairment and had experipheral vascular diversed accident (CVA) with hone side of the body) R53 was at risk for debut had no current prowere no pressures ulcars (CAA) dated 6/17/15, for skin impairment a s/p [status post] [follo ischemic attack] [minhemiparesis, Alz [Alz requiring assistance in needs, bowel and bla inability to communicatimes, Dx [diagnosis] PVD [peripheral vasc of PU [pressure ulcer to facility last year with contractures which in ulcers to heels/feet." "No current skin issue in the pressure skin issue in the physician of the property of the property of the pressure ulcer to facility last year with contractures which in ulcers to heels/feet."	tment; failed to obtain treatments and to notify the ges were made for treatment s; failed to perform ongoing essure ulcers; failed to each pressure ulcer as they evaluate and/ or modify ents; and failed to follow ations that were in place. Im Data Set (MDS) dated 3 had severe cognitive diagnosis including diabetes, isease, and cerebrovascular memiparesis (weakness on The MDS also indicated eveloping pressure ulcers, essure ulcers, and there cers on the prior Care Area Assessment indicated R53 was, "At risk and breakdown r/t [related to] wing] CVA /TIA [transient in stroke] w/ [with] (L) [left]	F	314	CNAs/Bath Aids on an immediate notification to a nurse of any new skin issues. Reviewed with CNAs about repositioning/toileting plans and implementing those. Pressure ulcers habeen included as a Quality improvement process. D: All wound documentation and interventions will be audited by DON or designee weekly x4 weeks then biweel x 1 month then monthly throughout the following year with results reported to Quality Council. DON/Designee to aud 10% of toileting plan/repositioning compliance weekly x4 weeks, Bi-weekl for a month then quarterly throughout the following year with results reported to Quality Council.	nt r kly dit	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		245360	B. WING _			10/2	; 20/2015	
	ROVIDER OR SUPPLIER	Y OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP C 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	:ODE	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
F 314	protectors while in be pressure mattress an wheelchair, and skin R53's most recent qu indicated R53 continu ulcers, and had one s	have the resident wear heel d, use of an alternating	F3	314				
	shallow open ulcer w without slough) that w MDS assessment, da During an observation nursing assistant (NA morning cares. R53 hright heel, was wearilleft foot, and both hee R53's bottom sheet careas of drainage. N from the right heel, and dressing covering the removed the sock frow beefy red colored precent, with 2 cm of surropasty white color local NA-B stated she had she needed to find the ulcer on the left heel for R53's left heel was recliner, and was not heel boots were note which velcroed on the heel was still touching not relieved from the blue boot. On 10/14/15, at 9:49	ith a red-pink wound bed was not present on the prior						

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	ROVIDER OR SUPPLIER	TY OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP COD 100 GLEN OAKS DRIVE NEW LONDON, MN 56273		0/20/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 314	with dressings and a the saturated dressir cultured the drainage ulcer. The right heel to be approximately surrounding tissue th LPN-B stated she wo knew about the presshowever, she was not ulcer on the left heel to summon registere R53's pressure ulcer entered R53's room R53 had a left heel prot aware it was operight heel pressure ulcer and described it as, length with 2 cm open 1.2 c.m. actual open what stage the left heel provided in the left heel and described it as, length with 2 cm open 1.2 c.m. actual open what stage the left heel pressure ulcer desident skin concern aware of R53's left homorning and stated, R53's Skin Risk Asset (a tool used to determine the left heel can be stated to the left he	culturette. LPN-B removed ag from the right heel and e on the right heel pressure pressure ulcer was observed 2-3 cm, beefy red, with at had a pasty white color. Orked with R53 daily, and sure ulcer on the right heel of aware R53 had a pressure also. LPN-B directed NA-C d nurse (RN)-C to assess son the heels. RN-C and stated she was aware ressure ulcer, but she was n. RN-C observed R53's licer and identified it as a cer, and stated the right heel nowever RN-C did not el pressure ulcer at that time 14.5 centimeters [cm] in n, and 3.7 [cm] width; with area." RN-C was unsure el pressure ulcer was. 10/14/15, at 10:29 a.m. rsing assistants should be d staff if they note any ns however, LPN-B was not neel pressure ulcer until this "No one had reported it." essment with Braden Scale mine pressure ulcer risk) tool fied the resident had a score	F3	14			

NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY OF NEW LONDON Major Department STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN DAKS DRIVE NEW LONDON, MIN 56273 DEPARTMENT OF DEFICIENCY MIST BE PRECEDED BY FULL PREFIX TAG PROVIDER'S FLAN OF CORRECTION (EACH OPERICENCY MIST BE PRECEDED BY FULL PREFIX TAG PROVIDER'S FLAN OF CORRECTION (EACH OPERICENCY MIST BE PRECEDED BY FULL PREFIX TAG PROVIDER'S FLAN OF CORRECTION (EACH OPERICENCY MIST BE PRECEDED BY FULL PREFIX TAG PROVIDER'S FLAN OF CORRECTION (EACH OPERICENCY) OWNER OF TAG PROVIDER'S FLAN OF CORRECTION (EACH OPERICENCY) OWNER PROVIDER'S FLAN OF CORRECTION (EACH OPERICAN O	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS BRIVE 10			245360	B. WING _		_	1)/2015	
F 314 Continued From page 48 The next skin assessment completed for R53 was tilled Observation Report, which included a summary under the Quarterly Review section dated 9/4/15, which indicated R53 continued to be at risk for skin breakdown and included; "Does have ho [history of] pressure on the heels. Staff to apply (B) [bilateral] heel boots while in bedHas had an open area to his lateral heel that appeared as a broken bilister related to shoe slipping as he was propelling himself around in WC [wheelchair]." The assessment did not indicate which heel had the pressure ulcer, and the assessment indicated R53 had developed an "open area," there were no new interventions developed to relieve pressure from R53's heels such as floating the heels, or applying heel boots which would relieve pressure we providing only protection to the heels. The undated Glenoaks Care Center-Maple 1 nursing assistant care sheet, (a direction for staff on specific cares for residents) directed staff to place the blue heel boots on R53 while in bed and			TY OF NEW LONDON		100 GLEN OAKS DRIVE		1 10/20	<i></i>	
The next skin assessment completed for R53 was titled Observation Report, which included a summary under the Quarterly Review section dated 9/4/15, which indicated R53 continued to be at risk for skin breakdown and included; "Does have h/o [history of] pressure ulcer to L [left] heel, due to contractures to hamstrings and knees are bent putting pressure on the heels. Staff to apply (B) [bilateral] heel boots while in bedHas had an open area to his lateral heel that appeared as a broken blister related to shoe slipping as he was propelling himself around in WC [wheelchair]." The assessment did not indicate which had the pressure ulcer, and the assessment identified interventions for staff to continue the repositioning plan of every 2 hours. Although the assessment indicated R53 had developed an "open area," there were no new interventions developed to relieve pressure from R53's heels such as floating the heels, or applying heel boots which would relieve pressure vs providing only protection to the heels. The undated Glenoaks Care Center-Maple 1 nursing assistant care sheet, (a direction for staff on specific cares for residents) directed staff to place the blue heel boots on R53 while in bed and	PREFIX	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORREC CROSS-REFEREN	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
recliner. The care sheet lacked direction to staff regarding repositioning R53 every two hours as assessed, and there was no direction to staff to monitor R53's skin for pressure ulcers. The nursing assistant care sheet did not give any direction to staff regarding repositioning or indicate R53 had, or was at risk for, pressure ulcers. R53's Resident Progress Notes from 8/13/15-10/14/15, identified the following:	F 314	The next skin assess was titled Observation summary under the Codated 9/4/15, which is be at risk for skin breshave h/o [history of] due to contractures the bent putting pressure (B) [bilateral] heel boopen area to his later broken blister related propelling himself and The assessment did the pressure ulcer, a interventions for staff plan of every 2 hours indicated R53 had deter were no new in relieve pressure from floating the heels, or would relieve pressur protection to the heel. The undated Glenoa nursing assistant car on specific cares for place the blue heel be recliner. The care shregarding repositionic assessed, and there monitor R53's skin for nursing assistant car direction to staff regaindicate R53 had, or ulcers. R53's Resident Prog	sment completed for R53 on Report, which included a Quarterly Review section indicated R53 continued to eakdown and included; "Does pressure ulcer to L [left] heel, to hamstrings and knees are e on the heels. Staff to apply tots while in bedHas had an iral heel that appeared as a if to shoe slipping as he was bound in WC [wheelchair]." inot indicate which heel had ind the assessment identified if to continue the repositioning is. Although the assessment eveloped an "open area," interventions developed to in R53's heels such as applying heel boots which ire vs providing only ils. Its Care Center-Maple 1 ie sheet, (a direction for staff residents) directed staff to isoots on R53 while in bed and it et lacked direction to staff ing R53 every two hours as it was no direction to staff to it pressure ulcers. The it is sheet did not give any it inding repositioning or it was at risk for, pressure in R513/15- in R53/15- in R	F3	314				

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		245360	B. WING _			C 10/20/2015
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F 314	Continued From page 8/13/15- R53, "Noted (L) [left] lateral heel who to aware if his shoes perhaps opened up a [centimeters]. After happlied. Instructed stagrippy sock was applarea." The note did rappearance of the wasurrounding skin, or tulcer. There was no drainage or discomforwhen interviewed on director of nursing (Donote on 8/13/15, shounded had the pressure 8/14/15- "Resident's from his shoe constant part of his foot when [wheelchair]. This apple [pressure ulcer]. Foal intact. Will have staff and only grippy socks which heel had the progress not (L) heel as well and will blanchable." The note	to have an open area on his with is [sic] bath. States he is a rub. Appears as blister that and measures 1.1 x 1.1 cm his bath, foam dressing was aff to leave his shoes off and fied. Nursing will monitor not identify the stage, bund bed, wound edges, the depth of the pressure indication if R53 had any reform the pressure ulcer. 10/16/15, at 8:55 a.m., ON) stated the progress all have identified the right ender, not the left. Theel is possibly from friction on the self propelling in w/c opears to be a Stage 2 PU on dressing is clean, dry, and not put shoes on either feet s." The note did not identify ressure ulcer, however, the ote also indicated, "Checked was slightly red but	F 3	DEFICIENC		
	message for daughte MD-A dated 8/14/15 is stage 2 pressure ulce 1.1 cm x 1.1 cm. App his shoes when he w the w/c [wheel chair].	d on PU to (L) heel and left r." A corresponding fax to ncluded, "Resident has a er to his (L) heel. Measuring ears to be from rubbing on ould self propel himself in Currently has foam eep wound clean and				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION	<u> </u>	(X3) DATE SURVEY COMPLETED		
		245360	B. WING _			1	20/2015	
	ROVIDER OR SUPPLIER	Y OF NEW LONDON		STREET ADDRESS 100 GLEN OAKS I NEW LONDON,		1 10	20/2010	
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F 314	socks onuntil the whaving blue boots [he in the recliner and in include any recomment the facility receive a reverifying the informat reviewed. When intered a.m., DON again state actually on R53's right 8/20/15- "PU to left he Note did not include a description of the presinterview on 10/16/15 stated the pressure unight heel, and not the 8/21/15- "Continues to lateral heel. No drain this. Applied a foam of identify the stage, me the wound bed, wour or the depth of the prindication if R53 had from the pressure ulcomment of the pre	e is going to have grippy ound is healed. Also will be sel protectors] on when he is bed." The fax did not endations from MD-A, nor did response from MD-A ion was received and rviewed on 10/16/15, at 8:55 ed the pressure ulcer was at heel, and not the left. eel intact." The Progress any measurements or ssure ulcer. During 5, at 8:55 a.m., DON again lorer was actually on R53's eleft. to have an area on his (R) age. No dressing was on dressing." The note did not easurements, appearance of ad edges, surrounding skin, essure ulcer. There was no any drainage or discomfort er. rogress Note or assessment sure ulcer (s) was dated which indicated R53's exated on the (R) lateral heel, 0.2 cm, with a small amount the resident denied any pain, and with normal saline and a	F	314				
	included, "Much impr healing. ARea [sic] is healing." The note d	ovement noted in the showing good signs of id not identify the stage of opearance of the wound bed,						

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NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY	OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP CO 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	DDE	10.20.20.10	
PREFIX (EACH DEFICIENCY N			(EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
or the depth of the wou 9/5/15- "Resident continuon-blanchable redden heel. Area measures 0. No drainage noted. Charegaderm Foam Adhes 9/13/15- "Dressing charto] serous [bodily fluid to transparent] drainage. It that hampered the adher Cleansed and dressed, reapplied." The note diappearance of the wou surrounding skin, or the ulcer. There was no included at this time. Skin pain, bruises, edema or pressure ulcer (s) were progress note, nor was pressure ulcer had hea 9/16/15- "Dressing chardrainage noted on old or piece of skin covering winfection. New Tegader applied." The note faile appearance of the wou the wound, and failed to experiencing any pain.	surrounding, the wound, nd. nues to have a small [sic] area to (R) lateral .5 x 0.5 cm. Skin is intact. anged dressing to a sive dressing." nged to (R) heel d/t [due ypically pale yellow and Has loose dry skin on heel esion of the dressing. pressure relieving boot id not identify the stage, nd bed, wound edges, edepth of the pressure dication if R53 had any essure ulcer. plications or concerns is intact. No redness, r sores noted." The heel not addressed in this there any indication the led. nged on Rt [right] heel, no dressing. Has a loose wound, no signs of m Foam adhesive d to include the size, the nd, the skin surrounding on note if the resident was tinues to have an area to	F3	314			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	Y OF NEW LONDON		100	REET ADDRESS, CITY, STATE, ZIP CODE O GLEN OAKS DRIVE EW LONDON, MN 56273	1 10/	20/2010	
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F 314	cream to heels." The size, the appearance surrounding the wour resident was experied 9/22/15-"Continues wheel. Resident was we came on shift so tenrifurther assessment of documented. 9/23/15- Indicated Resident was well and the left, assessment of the prothere was healing, not the physician had been been been been been been been bee	to air] and apply Eucerin to air] and apply Eucerin to note failed to include the of the wound, the skin and, and failed to note if the noing any pain. With dry are [sic] to R [right] to the aring shoes when writer his shoes removed." No for the pressure ulcer was a significant of the pressure ulcer was no essure ulcer to determine if or was there any indication	F	3314				
	covered with Tegade note did not assess ti pressure ulcer stage, was, or if R53 was ex no corresponding ass which were complete referred to in the about 10/5/15- Indicated Mil updated on right heel	ic] ointment to area and rm Foam Adhesive." The me ulcer to include the what the surrounding tissue experiencing pain. There was sessment from the rounds d on 9/25/15, which was we assessment. D-A and R53's family were pressure ulcer and the ff was using was applying						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 314	Foam Adhesive dres indication what inform MD-A, nor was there treatment for R53's r 10/6/15- "R heel inta 10/11/15- "Put new done on there. Noted sock." The note failer eferring to the right further assessment a pressure ulcer. 10/13/15- "Dressing ulcer d/t fully saturate yellow with small am dressing with some owith NS [normal salin to outer edges of wound 20% wound 80%. Resider Treatment changed fevery 7 days and PR every shift and change 50% saturated. MD wound. Awaiting repidence in the property of t	and covering with Tegaderm sing. There was no mation was shared with any changes to the light heel pressure ulcer. It is in the left of the left heel pressure ulcer. It is in the left heel did not having to have clear drainage on the left heel, and there was no left heel, serous anguinous [light left ounts of blood] fluid noted on left of heel, slough/dead skin noted left, slough/dead skin noted left, slough/dead skin noted left, beefy red in middle of left denied any pain to area. It is needed] to check ge daily or PRN if more than [MD-A] updated on status of left left left left left left left lef	F	314				
	III [3] at this time. Wo	erousanguinous fluid. Stage ound culture obtained and rder. Resident also has a e. Resident noted to have L						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	5.000		STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	1	0/20/2015
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F 314	of divitalized skin and cleansed with NS, sk with Tegaderm Foam has an air mattress of while in bed, only we been referred to WO wound. MD [MD-A] to heel. Potential for ref protective AFO's [a p foot and ankle in the while in bed d/t resid flexion contractures a most pressure is put current wound is a sur/t this issue. Daught Although on 10/14/15 observed to have preand left heel, there we monitoring of R53's landleft heel, there we monitoring of R53's landl	e III with Wound bed .2 cm with 2.5 cm x 2.5 cm und wound bed. Wound in prep applied and covered a dressing. Resident currently on bed, wears heel boots ars socks with no shoes, has C nurse, culture obtained on to be updated on new PU to L erral to Hagen Orthotics for lastic brace to support the proper position] for his heels ent having have [sic] knee and when resident is in bed on his lateral heels. This uspected deep tissue injury er also updated on this plan." 5, at 9:49 a.m. R53 was essure ulcers to both the right as no assessment or eft heel pressure ulcer until m. d 9/16/15, identified R53 was ment and had no current , "Heels intact." The care monitor skin with daily cares eel protectors on while in ion the resident every two I, lotion heels at bedtime, anges in condition/skin, and octor (MD) as needed. Even cumented R53 developed a e right heel on 8/13/15, the	F3	14		

A. BUILDING	(X3) DATE SURVEY COMPLETED	
245360 B. WING 10/	20/2015	
NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY OF NEW LONDON STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	20/2013	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314 Continued From page 55 pressure on his heels to ensure healing of the current pressure ulcers. Review of R53's Treatment Flowsheet, dated 8/1/15-8/31/15, included, "Heel boots on while in bed, check for proper placement. Every shift." A undated, handwritten note was added which indicated to wear the heel boots in recliner also. Although the facility identified R53 had a pressure ulcer on his right heel on 8/13/15, there was no treatment ordered/ documented on the Treatment Flowsheet for August 2015, to the current heel pressure ulcer(s). R53's Treatment Flowsheet, dated 9/1/15-9/30/15, included, "Check (R) heel dressing daily and change weekly on Thus [Thursday] til healed. Once a Day on Thu [Thursday] til healed. Once a Day on Thu [Thursday] til healed. Once a Day on Sy15. An undated, handwritten note was added next to the order which included, "Gom dressing" and "regaderm Foam Adhesive." R53's Treatment Flowsheet also included a handwritten note, implemented 9/19/15, which directed, "Check R heel q [every] NOC [night] notify if getting worse & make sure Eucerin is applied. The Treatment Flowsheet was initiated by staff to indicate the right heel pressure ulcer dressing was changed on 9/3/15, 9/5/15, 9/15/15, and was then left open to air on 9/19/15. Review of R53's medical record indicated the changing treatment to R53's pressure ulcer were nursing orders, not treatment orders obtained from the physician. R53's Standing Orders signed by the physician dated 4/26/14, directed staff, "May treat Stage I decubitus [pressure ulcer] per nursing order. Notify MD of stage 2 or greater ulcer for approval		

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F 314	followed up to determ for R53's worsening prearly two months after right heel pressure ull R53's Physician Prograted 9/25/15, indicated 9/25/15, indicated fleft heel pain. It may the area where his he ulcers or openings or is having pain." During interview on 1 stated during R53's vassessed R53's left have not open, howeveresidents right heel pashe was not aware the ulcer on the right heel aware of R53's right have 10/14/15, when the fastage 3 pressure ulcer stated she had never (8/14/15) regarding Repressure ulcer to his labeled to document wo stated she was new thad the position prior used to document wo stated she had been documentation. RN-Cany training regarding care, but she was plated.	with the physician and ine appropriate treatment pressure ulcer until 10/13/15, are the facility first noted the cer. ress Note written by MD-A and Red R53, "Complains today inly happens at night time in ealed ulcer is There are no in his left heel noted where he are shown in the ressure ulcer and it er, she did not assess the ressure ulcer at this time, as are resident had a pressure ulcer until exility notified her of the er on the left heel. MD-A received a fax in August 53 having a stage 2 eft heel. 0/14/15, at 1:50 p.m. RN-C on her role, and the RN who to her had a binder she und cares, however, RN-C unable to locate the costated she had not had a pressure ulcer and wound nning on going with RN-B rounds so RN-B could ure ulcer treatment,	F3	.14				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	I ' '	(X3) DATE SURVEY COMPLETED		
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F 314	p.m. RN-C stated a previous RN that he there was no wound assessment and moulcers would be four Progress Notes. During interview on stated she occasion and indicated staff v (heel protectors) on when he was in bed R53's Resident Profindicated "Dressing heel this am d/t dres were cleansed with covered with Tegadwrapped with kerlix for security. Heel bowhile in bed/recliner noted. Both wounds [thick, black, dry new An additional Resid 10/18/15, indicated, have a stage 2 pres Very first layer of sk cm, depth n/a. Wou Res peri skin [skin security security skin skin skin skin skin skin skin skin	nterview on 10/14/15, at 3:20 call had been placed to the eld her position and was told dicare binder; and any onitoring of resident pressure and in the Resident Nursing 10/16/15, at 12:56 p.m. NA-G ally assisted R53 with cares, were directed to put blue boots R53 to protect his heels	F	314				
	indicated, "Resider dressings, one on F saturated. Both dres drainage was a gree	gress Note dated 10/19/15, at had a shower this a.m., both RT and Lt heel were 50% asings were very foul smelling, en-tan in color. Did c/owhen old dressings removed,						

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F 314	Continued From page was repositioned whi		F	314				
	medicated with Tylen 7:00 a.m. Areas clear Tegaderm foam adhe Kerlix to prevent dres	ol 650 mg [milligrams] at nsed with NS, covered with esive and wrapped with ssings from falling off. Heels Z chair, has edema present						
	sent to MD-A indicate results of the residen Heavy growth noted of moderate growth noted of Attached are also cull be seeing WOC nurs bilateral heels which PU noted to bottom of antibiotic would you pany other orders?" More Augmentin 875 mand Although the facility row stage II pressure treatment options we was not made aware	(Fax Sheet dated 10/19/15, ed, "1.) Attached are the t's R heel wound [culture]. of proteus species and ed to Klebsiella pneumonia. ture/sensitivity. Resident will e tomorrow afternoon for are worsening and Stage II over the weekend. 2.) Which orefer to start resident on? MD-A responded with orders g twice daily for 7 days. notified the physician of the e ulcer on R53 coccyx, no re reviewed, and the MD of the measurements of the e ulcer to R53's coccyx.						
	indicating, "Okay to s [protein drink used to packet with 8 oz (oun meals for open areas Stage II PU to coccys During interview on 1 stated staff were dire both R53's feet witho recommendation had	to MD-A on 10/19/15, tart resident on Juven aid with wound healing] 1 aces) of fluid BID between to Bil (bilateral) heels and c?" MD-A replied with, "Yes." 0/19/15, at 9:41 a.m., NA-J cted to put heel boots on ut socks. NA-J stated this been made within the last e, "[R53] had sores on both						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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F 314	Continued From page	e 59	F 3	14			
	stated R53, "Has troushould not be wearing stated R53 had press and she believed it stand then developed a heel, "It's been a mor [pressure ulcers to be was directed about 3 boots (heel protectors socks on the resident During interview on 1 stated when staff noti regarding R53's press should have followed response from the ph not a treatment chang completed. DON starknow what took place first pressure ulcer to was not employed at	g shoes or socks. NA-K ure ulcers on both heels, arted on the right heel first, a pressure ulcer to the left th that he's had both oth heels]." NA-K stated she weeks ago to only put the s) on R53, and not to put any . 0/20/15, at 9:02 a.m. DON fied the physician via fax sure ulcer on 8/14/15, staff up if they did not receive a ysician to ensure there was ge that needed to be seed it was difficult for her to when R53 developed the the right heel because she the facility. DON stated, cedures were in place; The					
	had no cognitive impa	o staff for bed mobility,					
	resident was at risk for pressure, and R14 was and repositioned ever included extensive as	every two hours and as					

		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 314	and side-lying when i wound care was to be ostomy, and continent R14's Physician progindicated R14 had a puttock. No staging, assessment of the progress notes dated to be frequently reposin her chair. On 10/13/15, at 3:42 lying on her back in breceive the assistance repositioning, and she buttocks. R14 stated should be turning and relieve pressure, how not get repositioned the get help once during R14 was teary eyed a voice. Review of R14's progressioned the progression of R14's progre	and encourage use of bed in bed. It also identified a completed per wound, ce nurse. Tress note dated 9/22/15, pressure ulcer to her imeasurements, or further ressure ulcer was noted. A so the wound ostomy clinic. The continence (WOC) nurse 10/2/15, indicated R14 was sitioned hourly when seated in the season of the wound nurse stated she are repositioning often to rever, she stated she does that often, and, "Is lucky to the day and once at night." and speaking with a cracking in the ress notes dated 9/8/15 rue following: To [complained of] her as some open sores." The complained of the ressure of the control of the buttock appears slightly	F 31	4		

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F 314	(cm) x 3 cm, almost to the top and bottor purple. - 10/5/15- "Appears near rectum this am corresponding asses - 10/16/15- "Stage II Erythema across bu Previous Stage II an appears sealed over measuring 1.5 x 0.6 During continuous on 10/14/15, from 7:01 following was observed: - 7:01 a.m R14 was - 8:35 a.m. NA-C as dressed, R14 stated yet. NA-C offered R declined, and NA-C offered toileting or resident of the search of the searc	increased to 12 centimeters all open except a few areas in, and surrounding tissue is to have more open areas [morning]." There was no esiment of the open area. pressure ulcer to buttocks. Itocks 11.5 x 8.5 cm. Itocks 11.5 x 8.5 cm. Itocks an inject of the open area on right buttock cheek but is darker Erythema cm." In through 9:45 a.m. the open area on right buttock cheek but is darker Erythema cm." In through 9:45 a.m. the open area on right buttock cheek but is darker Erythema cm." In through 9:45 a.m. the open area on right buttock cheek but is darker Erythema cm." In through 9:45 a.m. the open area on right buttock cheek but is darker Erythema cm." In through 9:45 a.m. the open area on right buttock cheek but is darker Erythema cm." In through 9:45 a.m. the open area on right buttock cheek but is darker Erythema cm." In through 9:45 a.m. the open area on right buttock cheek but is darker Erythema cm." In through 9:45 a.m. the open area on right buttock cheek but is darker Erythema cm." In through 9:45 a.m. the open area on right buttock cheek but is darker Erythema cm." In through 9:45 a.m. the open area on right buttock cheek but is darker Erythema cm." In through 9:45 a.m. the open area on right buttock cheek but is darker Erythema cm." In through 9:45 a.m. the open area on right buttock cheek but is darker Erythema cm." In through 9:45 a.m. the open area on right buttock cheek buttock c	F	314				
	toileting every two h	e repositioned and offered ours, and stated the resident e 2 hours and 40 minutes						

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F 314	Continued From page	e 62 o toilet or reposition the	F;	314				
	resident. On 10/14/15, at 9:44 entered R14's room a right side. R14 was o but refused. During a follow up int p.m. R14 stated it is o on and wait 15 - 20 m and stated she is free assistance arrives. F walk by when the call back, and then turn th providing assistance. During interview on 1 stated R14 is frequent	a.m. LPN-C and NA-D and assisted R14 onto her offered toileting at this time, arview on 10/14/15, at 1:09 common to put the call light aninutes for staff assistance, quently incontinent before R14 also stated staff will light is on, say they will be the call light off without and 15/14/15, at 1:46 p.m. RN-B thy incontinent of bowel and 15/14/15 should be offering R14						
	performing a dressing ulcer on R14's buttoo dressing and stated the completely soiled with expectation the nursing nursing if a dressing with changed. RN-B assesstated the reddened a 8.5 centimeters (cm), area measured 1.5 x pressure ulcer was proposed in the proposed of the performance of the per	p.m. RN-B was observed g change to the pressure k. RN-B removed the old ne dressing appeared to be a feces, and it would be her ng assistants would report to was soiled so it could be assed R14's buttocks and area measured 11.5 cm x and the smaller, deeper red 0.6 cm. She stated the reviously a stage II, but was as not open.						

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F 314	Continued From page During interview on 1	e 63 0/16/15, at 10:28 a.m. NA-D	F	314				
	stated she believed For toileting and reposition always incontinent.	R14 was to be offered ning every hour, and was						
	stated she believed R repositioning and tolk RN-A stated R14 wou repositioning at times be offering and encou	0/16/15, at 10:58 a.m. RN-A 214 was to be offered eting every hour when sitting. ald refuse toileting and/ or , however, staff should still uraging R14 to toilet and nealing of the pressure ulcer.						
	of Skin Breakdown da policy to properly ider whose clinical conditi impaired skin integrity implement preventative appropriate treatment according to industry policy directed if a rest there was a new develocer, staff were to not therapy, and the care care sheets with skin Staff were directed to Ulcer Documentation Documentation form, wound monitoring where the pressure ulcer or area surrounding the complications such as pain management, ar or concerns in the number of the property of the pressure in the number of the property of the pressure ulcer or area surrounding the complications such as pain management, ar or concerns in the number of the property of the property of the property of the pressure ulcer or area surrounding the complications such as pain management, ar or concerns in the number of the property of th							
	The facility policy title	d Weekly Ulcer						

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	ROVIDER OR SUPPLIER	Y OF NEW LONDON		100	EET ADDRESS, CITY, STATE, ZIP CODE GLEN OAKS DRIVE N LONDON, MN 56273		
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F 314 F 315 SS=D	directed, "The Initial II Documentation form immediately upon ide ulcershould be com as appropriate." The document stage, leng odor, undermining, tu wound progress, and any changes.	Procedure dated 10/10 Ulcer & Weekly Ulcer should be started intification of pressure upleted at least weekly and policy directed staff to ith, width, depth, drainage, inneling, wound edges, and to notify the physician of		314			11/30/15
	resident who enters to indwelling catheter is resident's clinical concatheterization was now who is incontinent of treatment and services.	ity must ensure that a					
	by: Based on observation review, the facility fail assistance with toileti reviewed for urinary in dependent upon staff Findings include: R14's annual Minimu 9/8/15, identified R14	ng for 1 of 2 residents (R14) ncontinence, and who was		1 1 1 0 0 1	A: Identified resident □s toileting plan we reviewed and staff aware of current toileting program via care sheets. Resident refusals are being promptly reported to nurse and documented. B: All residents with routine toileting placould be affected were reviewed. C: It was reviewed with staff re: the importance of following routine toileting plans for all residents and promptly notifying nurse of resident refusals.	ans	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245360	B. WING			C 10/20/2015		
NAME OF P	ROVIDER OR SUPPLIER	2-10000		S	TREET ADDRESS, CITY, STATE, ZIP CODE	10/	20/2015	
TO WILL OF TH	TO VIDER OR OUT FEET				00 GLEN OAKS DRIVE			
BENEDIC	TINE LIVING COMMUNI	TY OF NEW LONDON		NEW LONDON, MN 56273				
(X4) ID PREFIX TAG			ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 315	Continued From pag	ge 65	F;	315				
	incontinence. R14's Urinary Incon	and have frequent urinary tinence Care Area dated 9/8/15, identified R14 to			Agency staff orientation checklist has been updated to include explanation o the care sheets, repositioning and toile records, and promptly notifying nurse or refusals of repositioning, toileting, and	eting		
	be incontinent of uring bathroom. Further, to, "continue toilet	ne on the way to the the CAA identified staff were ing plan of Toilet [sic] upon vo hours] during the day, and	re		other assistance. D: DON/Designee to audit 10% of toile plan compliance weekly x 4 weeks, biweekly for a month then quarterly throughout the following year with resu	•		
	identified R14 to hav listed a treatment pr Toileting/Habit Train	d staff to help R14 to the toilet			reported to Quality Council.			
	incontinence with int R14 with toileting up	ed 9/18/15, identified a risk for terventions including to help on on rising in the morning, then awake, every two hours request.						
	7:01 a.m. to 9:44 a.r her room. R14 was any toileting or incor and 43 minutes. Wh toileting or incontine 10/14/15, at 9:40 a.r	n. licensed practical nurse should have been assisted						
	stated she will freque have to wait for 15 to	10/14/15, at 1:09 p.m. R14 ently put her call light on and p 20 minutes to receive help becoming incontinent before						

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245360	B. WING			C 10/20/2015	
	ROVIDER OR SUPPLIER	Y OF NEW LONDON	STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273		•	10/20/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION DATE	
F 315	registered nurse (RN) offered toileting upon while she was awake should have been offer and 44 minutes passed. A facility Urinary Conf. Assessment and Mar 9/2010, identified state services and treatment.	10/16/15, at 10:58 a.m. 1-A stated R14 was to be rising, and every one hour. Further, RN-A added R14 ered toileting before 2 hours ed. Itinence and Incontinence - hagement policy dated if will provide appropriate int to help residents restore	F3	315			
F 318 SS=E	tract infections. 483.25(e)(2) INCREA IN RANGE OF MOTION Based on the compresident, the facility mount of the second of the compresident of the second of th	hensive assessment of a nust ensure that a resident f motion receives and services to increase or to prevent further	F 3	318		11/30/15	
	by: Based on observation review, the facility fail range of motion serving (R17, R24, R3 and R for restorative nursing Findings include: R17's annual Minimum	n, interview and document ed to consistently provide ces for 4 of 4 residents 29) in the sample reviewed g services. m Data Set (MDS) dated 7 had intact cognition, and		A: Residents identified are b with ROM per care plan. B: All residents that require s with ROM services were revice: Staff has been crossed trarehab/ROM to ensure that refreceiving appropriate ROM sometimes of the complete is a Rehab aide 5 days complete ROM/rehab.	staff assist ewed. ained in esidents are services. sure that a a week to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245360	B. WING _		1	C 0/20/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		0/20/2015	
				100 GLEN OAKS DRIVE			
BENEDIC	TINE LIVING COMMUNIT	IY OF NEW LONDON		NEW LONDON, MN 56273			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 318	Continued From pag	e 67	F 3	18			
	of daily living (ADLs) R17's ADL Function a Care Area Assessme identified R17 had m leg and no movemen able to participate as grooming. Further, ti	and Rehabilition Potential ent (CAA) dated 8/24/15, inimal movement of the left with the left hand, but was desired with dressing and he CAA identified R17 had in the past on several		designee will review 10% of documentation of ROM served 4 weeks, monthly x 3 month quarterly throughout the followith results reported to Quarterly throughout the followith results reported to Quarterly throughout the followith results reported to Quarterly throughout the following throughout throughout throughout the following throughout throu	rices weekly x s, then owing year		
	R17's care plan dated 9/2/15, identified R17 had hemiplegia (paralysis of one side of the body) and cerebrovascular disease, and identified an intervention of a restorative nursing program. The program included attending an "exercise group", and, "ROM [range of motion]" to his upper and lower extremities. Further, the care plan directed staff to "monitor for change" in R17's ability to participate in group exercises and assistance to complete his ADLs. R17's undated Restorative Nursing Program identified R17 should receive assisted active range of motion (AAROM), passive range of motion (PROM), and active range of motion (AROM) as follows:						
	abduction x (times) 1 and; > AAROM (R) elbow reps and; > AAROM (R) wrist in reps and;) shoulder in flexion and 0 repetitions (reps) each in flexion and extension x 10 in flexion and extension x 10 ers: make and open fist and for 10 reps and;					

AND DUAN OF CORDECTION IDENTIFICATION NUMBER.		1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245360	B. WING _			C 10/20/2015	
	ROVIDER OR SUPPLIER	1111		STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	l	10/20/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 318	abduction x 10 reps > PROM to (L) elbow 10 reps and; > PROM to (L) wrist reps and; > Passively stretch fit to tolerance for 1 min Lower Body: > Passive hamstring sides) lower extremit done while performin > AROM to AAROM reps and; > AROM to AAROM and flexion (kicks) x > Heel cord stretches. During observation of NA-A and NA-B assi transfer from the toile mechanical lift. R17 during the transfers, device using his righ R17's Restorative Flauring the transfers, device using his righ R17's Restorative Flauring the following services: > July 11 of 13 or > August 5 of 13 > September 4 of > October 1 of 4 In an interview on 10 registered nurse (RN managers" were in compared to the following services: In an interview on 10 registered nurse (RN managers" were in compared to the following services: In an interview on 10 registered nurse (RN managers" were in compared to the following services: In an interview on 10 registered nurse (RN managers" were in compared to the following services: In an interview on 10 registered nurse (RN managers" were in compared to the following services: In an interview on 10 registered nurse (RN managers" were in compared to the following services: In an interview on 10 registered nurse (RN managers" were in compared to the following services: In an interview on 10 registered nurse (RN managers" were in compared to the following services: In an interview on 10 registered nurse (RN managers") In an interview on 10 registered nurse (RN managers") In an interview on 10 registered nurse (RN managers") In an interview on 10 registered nurse (RN managers") In an interview on 10 registered nurse (RN managers") In an interview on 10 registered nurse (RN managers") In an interview on 10 registered nurse (RN managers") In an interview on 10 registered nurse (RN managers") In an interview on 10 registered nurse (RN managers") In an interview on 10 registered nurse (RN managers") In an interview on 10 registered nurse (RN managers") In an interview on 10 registere	noulder in flexion and each and; in flexion and extension x in flexion and extension x 10 ingers and thumb of left hand nute. stretches to bilateral (both ies for 3-5 minutes (could be ing upper body activities) and; (R) and (L) hop flexion x 10 inguities (R) and (E) in the field in the fi	F3	18			

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP IDENTIFICATION NUMBER: A. BUILDING			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245360	B. WING	B. WING		C 10/20/2015	
	ROVIDER OR SUPPLIER	Y OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273			20/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 318	F 318 Continued From page 69		F:	318			
	programs "are getting she "did not know" if done consistently. R primary restorative ai leaving the facility, rig someone who wants	oring progress, as well if the done or note." RN-A said the programs were getting N-A stated there was one de, and her back up is that now have "not found to step in."					
	restorative aide (RA)- to see R17 "three tim restorative program, v and lower extremities "arthritis on his weak has had changes or o abilities. RA-B also s in a daily "wellness po department staff. RA months she had been because the facility w was not getting his re completed as it shoul stated she knew resto important, but there "	B stated she was supposed es a week" for his which included his upper . RA-B said R17 had knee," but denied that R17 lecline in his functional aid R17 usually participated rogram" run by the activity -B stated the past few a working "more on the floor" as "short staffed", and R17 storative program d have been. Further, RA-B prative programs were was nothing we can do."					
	physical therapist (PT have a stronger followare discharged from that a weekly meeting the resident and the resident would be disand it "did not matter" getting therapy or waw alking program." Thus to "catch things" b functionality. The PT "were not" consistent	cussed" at least monthly, whether a resident was s on a range of motion or ne PT said it was a way for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245360	B. WING _	B. WING		C 10/20/2015	
	ROVIDER OR SUPPLIER	TY OF NEW LONDON	STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273			10/20/2010	
(X4) ID PREFIX TAG			ID PREFIX TAG	((EACH CORRECTIVE A CROSS-REFERENCED T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		N
F 318	"we still have to take R24's annual Minimu 7/22/15, identified R2 required extensive as mobility and transferr limitations in range or impairment to upper R24's ADL Function Care Area Assessmedidentified R24 had his contractures and limitextremities. Further, to help maintain his limitextremities function contractures to all exto maintain the ability and remain able to fedidentified intervention provide massage to have a range of motion, pass (PROM) to left upper range of motion (AAF extremity, and bilater with weights, knee excurls. During an observation R24 was sitting in a range and lower extremities R24 moved his right elbow bent.	m Data Set (MDS) dated 4 had intact cognition, sistance of two staff for bed ring, and had functional f motion (ROM) with bilateral and lower extremities. and Rehabilitation Potential and knee flexion ted ROM to bilateral upper R24 had a restorative plan imited functioning. d 10/11/15, identified R24 had range of motion with tremities and included a goal of to bear weight for transfers are himself. The care plan is including for staff to his neck prior to starting sive range of motion extremity, active assistive	F3	318			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245360	B. WING _			C 10/20/2015	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 318	not consistently getting short of help." R24 states do as much as I can, R24's Restorative Flooring included, "Prior to RC [warming gel] massage decrease tone, then sincluded, staff were colleft upper extremity, wextremity, and 4# wextension kicks, and band 3 x 10 to bilater Monday, Wednesday R24's Restorative Flooring R24's Restorative Flooring had been do follows: > July 2015 > August 2015	besed to work" with the e times a week, but it was no done "because they're tated when that happens, "I myself." by wheet, dated 1/23/15, by Start with Sombra ge to neck, stretch neck to shoulders, elbow." Also directed to provide PROM to AAROM to right upper hights hip flexion, knee hamstring curls with blue al lower extremities, on and Friday.	F3				
	> October 2015 During an interview of physical therapist (Procomplete therapy and recommended, and be restorative program. monitor the program completed. Further, having his restorative as directed to maintal.	1 of 8 opportunities n 10/14/15, at 2:26 p.m. T)-A stated when residents naintenance program is secomes a nursing Nursing was responsible to and make sure its PT-A stated R24 should be ROM program completed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245360	B. WING			C 10/20/2015		
	ROVIDER OR SUPPLIER	TY OF NEW LONDON		100	REET ADDRESS, CITY, STATE, ZIP CODE OGLEN OAKS DRIVE EW LONDON, MN 56273	1 10	20/2010	
(X4) ID PREFIX TAG			ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 318	his restorative prograte the documentation of was "accurate." RApulled to the floor to restorative programs complete "less and le were trained to compand the lack of the programs becoming upset "Residents get frustrand walking aren't do R3's annual Minimum 9/19/15, identified R3 impairment, required staff for bed mobility, staff for transfers. Funda bilateral mobility extremities, and recent ROM. R3's care plan dated intervention for staff of PROM including dors 15 reps each foot, he three times weekly at R3's Restorative Flow identified an order for passive range of mot dorsiflexion (toes upward) 15 reps estretches (toes upward) three reps to each Sunday, Tuesday, and a week. R3's Restorative Flow identified and intervention for staff of passive range of mot dorsiflexion (toes upward) 15 reps estretches (toes u	am three times a week,and in the Restorative Flowsheet A stated he had been getting do cares instead of , so they have been getting less." Further, only two staff lete restorative programs, rograms being completed ting to the residents, leted when their exercises one." In Data Set (MDS) dated Is had moderate cognitive extensive assistance of two and total dependence of two and total depende	F	318				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245360	B. WING _			C 10/20/2015	
	ROVIDER OR SUPPLIER	Y OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP CO 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	ODE	1 10/2	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE ACTIV	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
F 318	documented as comp > June 2015 > July 2015 9 > August 2015 > September 2015 > October 2015 1 When interviewed on restorative aide (RA)-restorative services a Restorative Flowshee are not being consist-restorative aides are with cares due to being typically scheduled to programs four days a pulled away from the The nursing assistant do they complete res RA-A stated these conthe former director of R29's quarterly Minim 8/29/15, identified R2 memory problems, where the care plan dated "at moderate risk" of "limited" ROM to her the care plan identified up to 3 X [times] were recommendations." Review of the Restorestores.	10 of 13 opportunities 1 of 13 opportunities 4 of 13 opportunities 1 of 13 opportunities 1 of 13 opportunities 1 of 13 opportunities 10/16/15, at 8:07 a.m. A stated the provided are identified on the et. The restorative programs ently completed as the pulled to the floor to help and short staffed. RA-A is a work on restorative a week, but is consistently and three of the four days. ats (NA) are not trained, nor attorative programs. Further, ancerns had been reported to a nursing (DON). The Data Set (MDS) dated 19 had long and short term as totally dependent on staff and limitations in her ROM on y. d 9/4/15, identified R29 was contractures, and had bilateral shoulders. Further, and an intervention of, "PROM kly per therapy attive Flowsheet Records /15 identified that PROM	F3	318			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		245360	B. WING _				20/2015
	ROVIDER OR SUPPLIER	TY OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP CO 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIA		(X5) COMPLETION DATE
F 318	Restorative Flowsher received the following y July 2015 > August 2015 > September 2015 > October 2015 > October 2015 > When interviewed on restorative aide (RA) getting pulled to the frestorative programs had been getting con Further, only two star restorative programs programs being comupsetting to the resid A facility Range of M 10/2010, identified st plan and therapy recompleting ROM for document the date a completed, and how completed for each restorative programs being completed for each residual to the residual to	et Records identified R29's g PROM: 10 of 13 opportunities 5 of 13 opportunities 2 of 13 opportunities 2 of 7 opportunities 10/16/15, at 7:59 a.m., -A stated he had been floor to do cares instead of, so the restorative programs inpleted "less and less." If were trained to complete, and the lack of the pleted was becoming lents. otion Exercises policy dated aff should review the care commendations prior to each resident, and ind time, type of exercise long the exercise was esident. NT 24-HR NURSING STAFF e sufficient nursing staff to related services to attain or practicable physical, mental, ll-being of each resident, as ant assessments and ire.	F3				11/30/15

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245360 B. WING	C 10/20/2015	
NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY OF NEW LONDON STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	10/20/2010	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide sufficent staffing to ensure the assessed needs and services were provided for 2 of 2 residents (R53 and R14) reviewed for pressure ulcers, which resulted in actual harm for R53. In addition, the facility failed to provide adequate staffing to ensure residents received required assistance with activities of daily living (ADL's) for 13 of 47 (R47, R35, R17, R24, R57, R33, R28, R53, R40, R17, R12, R57, R33) residents who resided in the facility needing staff assistance for ADL's, and/or who voiced concerns of insufficient staffing. Further, the facility did not provide restorative nursing, for 4 of 4 residents (R17, R24, R3 and R29) reviewed for range of motion. The lack of staffing had the potential to affect all 47 residents in the facility. Additionally, for lack of staffing concerns were expressed by 1 of 3 family members (FM-A), and 5 of 22 employees, (LPN-A, NA-D, NA-I, NA-O, and housekeeping assistant (HK)-A, expressed concerns about resident cares and treatments not		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245200		B. WING		С	
		245360	B. WING_			10/	20/2015
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON			00 GLEN OAKS DRIVE		
				N	IEW LONDON, MN 56273		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353		ollowing morning routine	F	353	and if the residents needs are being me These will be asked at resident council care conferences, and with audit. D: Weekly audits of bathing/rehab. hou	,	
	for choices. Refer to I information.		x4, biweekly x2 then monthly to be completed by staffing coordinator/D rehab/bath aid hours and reported to Quality Council. DON/Designee to a			it 3	
	ambulation services f R28, R53 and R57) re nursing. Refer to F31	ices for 4 of 5 residents (R35, month to I 57) reviewed for restorative residents o F311 for additional information.		month to Inquire about staffing and if residents needs are met. Results of the staffing interviews will be reported mon to Quality council.	o Inquire about staffing and if s needs are met. Results of the nterviews will be reported monthly		
	for 6 of 7 residents (Rand R24), who were	rovide bathing assistance 117, R35, R57, R33, R47 dependent upon staff for 2 for additional information.					
	minimize skin breakd (R53 and R14) review This resulted in actua	nplement interventions to own for 2 of 2 residents wed for pressure ulcers. I harm for R53, who had bers. Refer to F314 for					
	toileting to promote un residents (R14) depe	rovide timely assistance with rinary continence for 1 of 2 ndent upon staff for toileting F315 for further information.					
	necessary services to for 4 of 4 residents (R	onsistently provide the o maintain range of motion k17, R24, R3 and R29) le. Refer to F318 for further					
	RESIDENT COMPLA	INTS					
	R40's quarterly Minir	num Data Set (MDS) dated					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		I DENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245360	B. WING _			C 10/20/2015		
	ROVIDER OR SUPPLIER	TY OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP COD 100 GLEN OAKS DRIVE NEW LONDON, MN 56273		0/20/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 353	impairment, and requibathing and supervising grooming, and mobility did aide, and she was subtwice a week, howeves she did not recieve his scheduled for it, and week since she had a bathing. R17's annual MDS direction and most according interview on 1 stated he was supposed week, however, he did howe	e resident had no cognitive sired physical assistance with on of staff for dressing, ity. 0/12/2015, at 5:07 p.m. R40 not have a consistent bath apposed to be getting a bath er, due to the lack of staffing, er bath when she was thought it had been about a recieved assistance with atted 8/24/15, indicated the itive impairment, required for transferring, bed stivities of daily living (ADLs). 0/12/15, at 7:29 p.m. R17 sed to get bathed twice a poes not always get his baths Not enough people [staff] is bath. R17 stated, "It does don't get my bath."	F 3	.53				
	and she had soiled h assistance with toilet that," and stated wait	erself having to wait for ing. R12 stated, "I don't like ing for help to the bathroom ort staffed, "Is something that						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
						C 10/20/2015		
	ROVIDER OR SUPPLIER	TY OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP CO 100 GLEN OAKS DRIVE NEW LONDON, MN 56273		0/20/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 353	resident had no cognine required extensive as walking, and most All During interview on stated he was, "Frus receiving his schedul did not have enough FAMILY COMPLAIN Family member (FM) 10/13/15, at 10:57 as staffed, and feels that have cut back on stated back on state housekeeping had comothers wheelchair in no staff to clean it. STAFF COMPLAINT Licensed practical numbers wheelchair in the stated bath aides we cover shifts, and resisted bath aides we completed due to the stated bath aides we completed due to the stated bath aides we completed to work on the floor was no staff to complete also stated the restor to work on the floor was no staff to complete as stated the restor to work on the floor was no staff to complete as stated the restor to work on the floor was no staff to complete as stated the restor to work on the floor was no staff to complete as stated the restor to work on the floor was no staff to complete as stated the restor to work on the floor was no staff to complete as stated the restor to work on the floor was no staff to complete as stated the restor to work on the floor was no staff to complete as stated the restor to work on the floor was no staff to complete as stated the restor to work on the floor was no staff to complete as stated the restor to work on the floor was no staff to complete as the floor was no staff	dated 9/10/15, indicated the littive impairment, and saistance with transferring, DLs. 10/12/15, at 6:30 p.m. R57 trated," because he was not led bath because the facility staff. TS 0-A during interview on m. stated the facility is short at many of the departments ff. FM-A stated even at back on staff, and her is often dirty because there is Surse (LPN)-A during interview p.m.stated the facility often lency staff in the mornings to dent baths were not getting a lack of staffing. LPN-A are needed to work as NA's in the floor, therefore, there lete resident baths. LPN-A rative aides were often pulled when they should be assisting estorative program, however, staffed so they needed to	F3	53				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	, , ,	(X3) DATE SURVEY COMPLETED		
		245360	B. WING _			C 10/20/2015	
	ROVIDER OR SUPPLIER	IITY OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP COD 100 GLEN OAKS DRIVE NEW LONDON, MN 56273		10/20/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 353	aide, and it was diff baths. NA-D stated the schedule, they, floor," to assist with facility does not have required resident cannot be stated she, "Gets and does not get done, to the administration inability to complete short staffing. NA-A toileting, and repo [done." NA-I stated because there was residents out of because all cleaning. Housekeeping assistant of the concerns of not have ensure all cleaning HK-A stated house	d not currently have a bath icult to complete resident I when there is a bath aide on "Often get pulled to work the resident cares because the ve enough staff to provide the ares. w on 10/14/15, at 1:24 p.m. ngry," when resident bathing and had brought her concerns a several times regarding the eresident cares related to A stated, "I know the turning, repositioning] are not getting breakfast also gets delayed not enough staff to get the I timely, and also basic always get completed related stant (HK)-A during interview of p.m. stated housekeeping down, and there were ving enough staff and time to duties were being completed. keeping was not always able	F3	353			
	wiping down baseb and furniture were I lack of staffing. NA-O during intervi stated R35 would b have time to walk h have enough staff t	ew on 10/19/15, at 3:12 p.m. e able to walk if staff would er, however, the facility did not o ensure the residents were orative care they had been					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	ON	(X3) DATE SURVEY COMPLETED		
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F 353	Continued From pag	e 80	F	353			
	10/14/15, at 2:40 p.r. bath aide and the rest reassigned to assist bit." SC-A stated should concern to the receiving their baths, working on trying to aides. SC-A stated to concerns with lack of (early morning), and discussing solutions, request to present stavailable hours. SC-no changes related to lack of staffing, and to	and there is an ongoing aff to assist with any open A stated there were currently to taking admissions due to the facility was currently and only in the color of					
	director of nursing (D "doing a lot of intervi- and acknowledged th get residents up in th acknowledged staffir facility, and the facilit increase," and also h were offering "more sin in to work. The DON "flexible scheduling" looking to post a post nursing], and were a staff trained and cross	/16/2015 at 12:02 p.m., the PON) stated they had been ewing" regarding staffing, nat it was often difficult "to be mornings." The DON on the mornings." The DON on the mornings." The DON on the mornings on bonuses and "sign on bonuses" and scholarships" to draw people of also said they were offering to accommodate staff, were distingted in the more of t					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		245360	B. WING			10/	20/2015
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F 353	Continued From page	e 81	F	353			
F 431	administrator, director registered nurse (RN)	UG RECORDS,	F	431			11/30/15
SS=E	The facility must emp a licensed pharmacis of records of receipt a controlled drugs in su accurate reconciliatio records are in order a	loy or obtain the services of twho establishes a system					
	_	y and cautionary					
	facility must store all olocked compartments	tate and Federal laws, the drugs and biologicals in under proper temperature only authorized personnel to eys.					
	permanently affixed of controlled drugs listed Comprehensive Drug Control Act of 1976 a	ide separately locked, compartments for storage of d in Schedule II of the Abuse Prevention and nd other drugs subject to he facility uses single unit					

B. WING _			С	
		1 10	C 10/20/2015	
	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10	72072010	
	100 GLEN OAKS DRIVE			
	NEW LONDON, MN 56273			
ID PREFIX TAG	((EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE	
F 4	31			
	were last checked for open dates determined that pens were opener after this date. Pens were dated we last date checked. B: Insulin pens and vials were revon all medication carts for date opens of dating insulin and to form MAR verification dates. It was revolved with staff on the importance of verification dates. D: All insulin pens and vials will be weekly x4, biweekly x4 then more be completed by nurses giving insumedication carts, with results report DON or designee and Quality Councillation. A: Bubble packs that were noted to tape on them immediately reviewed imprint to ensure that there was not tampering. Packs were removed for medication lock box that was tape. Notification sent out to staff that to bubble packs should never be done B: All narcotic bubble packs were reviewed on 10/21/15 with no evic tampering. C: TMAs/LPN/RNs have been edicated.	and d on or with the dewed ened. In the llow the ewed ifying use to e audited thly. To ulin on wred to uncil. In the control of the control of the d. In the lence of leacted		
	PREFIX TAG	A: Staff referred to the date insulin were last checked for open dates determined that pens were opener after this date. Pens were dated we last date checked. B: Insulin pens and vials were revious all medication carts for date open dates. It was revi with staff on the importance of ver open dates every time the pen is to prevent risk for expired meds. D: All insulin pens and vials will be Weekly x4, biweekly x4 then mont be completed by nurses giving ins medication carts, with results repo DON or designee and Quality Cou. A: Bubble packs that were noted to tape on them immediately reviewed imprint to ensure that there was not tampering. Packs were removed fi medication lock box that was tape Notification sent out to staff that a bubble packs should never be dor B: All narcotic bubble packs were reviewed on 10/21/15 with no evid tampering. C: TMAS/LPN/RNs have been educe.	PREFIX TAG A: Staff referred to the date insulin pens were last checked for open dates and determined that pens were opened on or after this date. Pens were dated with the last date checked. B: Insulin pens and vials were reviewed on all medication carts for date opened. C: Nurses have been educated on the process of dating insulin and to follow the MAR verification dates. It was reviewed with staff on the importance of verifying open dates every time the pen is use to prevent risk for expired meds. D: All insulin pens and vials will be audited Weekly x4, biweekly x4 then monthly. To be completed by nurses giving insulin on medication carts, with results reported to DON or designee and Quality Council. A: Bubble packs that were noted to have tape on them immediately reviewed for pill imprint to ensure that there was no tampering. Packs were removed from the medication lock box that was taped. Notification sent out to staff that taping the bubble packs should never be done. B: All narcotic bubble packs were reviewed or 10/21/15 with no evidence of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		245360	B. WING _			1	C 20/2015	
NAME OF P	ROVIDER OR SUPPLIER	l		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	20/2013	
				10	00 GLEN OAKS DRIVE			
BENEDIC	TINE LIVING COMMU	NITY OF NEW LONDON		N	IEW LONDON, MN 56273			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 431	stated she comple controlled substandary packages to have being removed. Ra medication, or ta does not use it, it is the packaging to be stated she was not which addressed to which addressed to when interviewed consulting pharmanoticed medication packaging during had medications need saved for use later. During interviewed saved for use later. When interviewed saved for use later. When interviewed DON stated any mon the back of the and destroyed. A facility Controlled 12/2012, lacked and staff should return packaging. A facility supplied A Medications at Gledated 7/2015, identifications.	n 10/16/15, at 2:27 p.m. RN-A ted a monthly audit of the ces, and noted some of the pills taped back inside after N-A stated if a resident refuses kes it to an appointment but is returned and taped back into e reused later. Further, RN-A traware of any facility policy his process. on 10/16/15, at 2:51 p.m. the cist stated he had never is being taped back into the his visits, however added those to be disposed of and not ron. In 10/19/15, at 1:40 p.m. the acist stated any medications ig removed from the bubble to be destroyed, and not	F	431	the blister packs to be destroyed per policy. New Narcotic policy with indicat on unused narcotics was reviewed with nurses/TMAs. D: Narcotic Audit will be completed we x4 weeks then monthly to ensure narcotics have proper count, imprint, current use, and no evidence of taping tampering present. Results will be monitored by DON or designee with results reported to the Quality Council.	n all ekly or		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		COMPLETED
		245360	B. WING _			C 10/20/2015
	ROVIDER OR SUPPLIER	TY OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	'	10/20/20 10
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 431	Continued From pag	e 84	F 4	31		
	UNDATED INSULIN					
	facility on 10/16/15, a practical nurse (LPN flexpens were noted use: > Lantus (injectable in R53. The flexpen was removed, but not dat to ensure it was not expensed with doses rowhen it was opened in the flexpen was opened in the flexpen was opened.)	of two medication carts in the at 1:12 p.m. with licensed as licensed as labeled for resident as opened with doses at 1:12 p.m. was opened to ensure it 1:12 p.m. with licensed with licensed at 1:12 p.m. with licensed with licensed at 1:12 p.m. with licensed with licen				
	stated the facility pol it was opened to ens	uring the observation dating on the insulin, LPN-A icy was to date insulin when ure it would not expire while the flexpens should have				
	director of nursing (E	10/16/15, at 1:22 p.m. the DON) stated when insulin is frigerator and opened, it is to I.				
F 441	dated 4/07, identified containers shall inclusuch as the expiration	Medication Containers policy I labels for individual drug ide all necessary information, in date when applicable. CONTROL, PREVENT	F 4	41		11/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245360	B. WING_		C 10/20/2015	
	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP CO 100 GLEN OAKS DRIVE NEW LONDON, MN 56273		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) (CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE COMPLETION THE APPROPRIATE DATE	
F 441 SS=F	Continued From pag SPREAD, LINENS	e 85	F4	141		
	Infection Control Prosafe, sanitary and co to help prevent the dof disease and infect (a) Infection Control The facility must esta Program under which (1) Investigates, continuthe facility; (2) Decides what proshould be applied to (3) Maintains a reconsactions related to infection (b) Preventing Spread (1) When the Infection determines that a respreyent the spread of isolate the resident. (2) The facility must promunicable disease from direct contact will train (3) The facility must professional practice (c) Linens Personnel must hands	Program ablish an Infection Control in it - trols, and prevents infections acedures, such as isolation, an individual resident; and d of incidents and corrective ections. In a control Program sident needs isolation to f infection, the facility must prohibit employees with a use or infected skin lesions with residents or their food, if insmit the disease. In a control program sident needs isolation to f infection, the facility must prohibit employees with a use or infected skin lesions with residents or their food, if insmit the disease. In a control program sident needs isolation to f infection, the facility must prohibit employees with a use or infected skin lesions with residents or their food, if insmit the disease. In a control program sident needs isolation to f infection to f infecti				

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	I \ /	TE SURVEY MPLETED
		245360	B. WING			C 0/20/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		0/20/2015
				100 GLEN OAKS DRIVE		
BENEDIC	TINE LIVING COMMUNI	TY OF NEW LONDON		NEW LONDON, MN 56273		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 441	Continued From pag	e 86	F 44	41		
F 44 I	This REQUIREMENT by: Based on observation review, the facility fair control program to intrending and analysist transmission to other This had potential to residing in the facility failed to ensure hand reduce the potential residents (R24, R31, were observed durintereduce the potential residents (R24, R31, were observed durintereduce). LACK OF COMPREICONTROL PROGRAMAN untitled infections. Seven residents experised a flooresident infections.	on, interview and document led to implement an infection clude consistent monitoring, so of infections to reduce the residents in the facility. affect all 47 residents in the facility dwashing was completed to spread of infection for 4 of 6 R14, R57) whose cares g the survey. HENSIVE INFECTION AM: Tog document dated June wheet for staff to record The flowsheet identified erienced an infection in the with the last recorded 17/15. The flowsheet ecord the following and trend infections:	F 44	A, B, C: All staff will be trained washing and handling of soiled Hand washing was added to orientation checklist for controcomplete prior to their work of Policy for soiled linens update always bag any soiled linens leaving a residents room to the Nursing staff educated on notice for recheck UA if symptoms is resolved. It was discovered the different infection logs in rotate were replaced with a consister log with "symptoms" added a infection was cultured or not, symptoms/infection resolved created for symptoms such a Vomiting/cold symptoms trace would not be on the "infection not starting an antibiotic. Case and infection control nurse eathese Logs and the need for documentation. D: Hand washing and soiled handling audit to be completed weeks bi- weekly for 1 mor monthly. Results will be mon DON or designee with results.	ed linen. the fact staff to on the floor. ed to include: before ransport. ot asking MD have o have 2 cition. These ent Infection and notation if and when date. Log as cking that on log" due to se Managers ducated on consistent linen ed weekly for oth then itored by	
	> Room Number > If Present Upon Ac > Type of Infection (i [UTI], gastrointestina > Antibiotic (with star The flowsheet consis	Imission .e. urinary tract infection I illness [GI], etc.) and, t and end dates). stently identified the residents on, and type of infection,		the Quality Council. Infection Symptom log will be audited basis by DON or designee for of documentation with results Quality Council. All residents are being Audited on a month inappropriate recheck Urinally results reported to the Quality	log and on a monthly or completion s reported to with UTIs only basis for ysis with	

Facility ID: 00314

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SU COMPLET	
		245360	B. WING _			C 10/20 /	/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	10/20/	72013
				100 GLEN OAKS DRIVE			
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		NEW LONDON, MN 56273			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	_	(X5) COMPLETION DATE
F 441	Continued From page	e 87	F4	141			
	identification, and ant as directed be filled o	ibiotic start and stop dates ut by the flowsheet.					
	September 2015, was different flowsheet in infections. The form the following informat > Resident name > Room > If present upon adn > Organism > Type of infection (i. (UTI), gastrointestina The September 2015 having an infection for R29 were identified h written underneath of and were located in a Lane unit. R26, R28 has having a "GI" infet the report identified the two residents had a leand one resident had the log lacked consist organisms causing the infection, nor the date documentation of the the start or stopping of were used to treat eafacility September 20 identified the docume collected information. The report identified the experienced, "Three episodes of vomiting however added there among residents and	included spaces to identify ion: nission e. urinary tract infection I infection (GI), etc) data listed ten residents as or the month. R26, R28, and as having an "emesis" I the "Organism" heading, adjacent rooms on the Maple and R29 were all identified ection on the report. Further, pree residents had a UTI, ower respiratory infection, a skin infection. However, tent identification of the enifection, symptoms of the enifection, symptoms of the enifection and the entry started or resolved, room for each resident, and date of antibiotics which characteristics and the as presented by the facility.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		PLETED
		245360	B. WING _			1	C 20/2015
	ROVIDER OR SUPPLIER	TY OF NEW LONDON		10	REET ADDRESS, CITY, STATE, ZIP CODE 10 GLEN OAKS DRIVE EW LONDON, MN 56273	10,	20/2010
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F 441	Continued From pag	ne 88	F4	441			
	having the same syr and 9/20/15.	nptoms on 9/7/15, 9/13/15,					
	registered nurse (RN nursing (DON) states the collection and ar The data is reviewed typed up and attached 2015 infections reported monthly Quality Assistated no tracking or resident symptoms, The organism(s) well provided, and no fur identified besides who surveyors as their in	10/20/15, at 1:05 p.m. N)-A and the director of d RN-A was responsible for halysis of the infection data. If by RN-A, an analysis is ed to the data (i.e. September rt) and it is discussed at the urance (QA) meetings. RN-A retrending was completed of date they began and ceased. The tracked on the flowsheet's ther documentation was nat was provided to the fection control program. The infection control program none was provided.					
	ANTIBIOTIC STEWA						
	identified R2, whom unit, completed a "th after having positive analysis / urinary cul the, "Final recheck wignificant growth." identify any signs or	However, the report did not symptoms R29 was ant a repeat urine screening					
	6/30/15, identified Rithat grew out e-coli [nmary Report dated 6/1/15 to 29 had a "UTI identify [sic] a bacteria] Started on 250 mg BId [sic, twice a day]					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245360	B. WING _			C 10/20/2015	
	ROVIDER OR SUPPLIER	ITY OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP C 100 GLEN OAKS DRIVE NEW LONDON, MN 56273			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 441	symptoms of UTI' During interview on stated it was up to trepeat UA/UC shou physician decision", physicians who see routinely order a fol Further, RN-A state request a follow-up treated with antibiot symptoms. LACK OF HAND H' During observation at 7:59 a.m. nursing perineal cares using assisted R24 to turr cleaned incontinent With his soiled glov R24's pants, adjust brace to his left food gloves and removed the bed; unlocked Fplacing it next to the the chair. NA-A cle the room, then remodisposing of them ir room without washi	days] [R29] does not have	F 4	141			
	resident. During an interview NA-A stated he sho gloves after perform	on 10/14/15, at 8:49 a.m. uld have removed the soiled ning perineal care, and should ands prior to leaving R24's					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	l' '	TE SURVEY MPLETED
		245360	B. WING			C 0/20/2015
	ROVIDER OR SUPPLIER	TY OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	<u> </u>	0/20/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	was just nervous." During observation of at 6:28 a.m. R31 was assistant (NA)-H wit R31's incontinence prompleted perineal of incontinence pad. No gloves and assisted placing a mechanical lift to trachair. NA-H did not removing her gloves complete perineal carrier R31 to the commons returned to his room supplies from his more hands after place soiled utility closet. When interviewed on NA-H stated she she after removing her gloves bedpan. RN-B complete perineal carrier removing her gloves bedpan. RN-B complete perine gloves bedpan. RN-B complete perine gloves bedpan. RN-B complete gloves	other resident, "I know that. I of morning cares on 10/15/15, is being assisted by nursing had ressing. NA-H removed bad with gloved hands, cares and applied a new la-H removed her soiled R31 to turn onto his side, all lift sling underneath of him. and returned with a insfer R31 from bed to his wash her hands after which were used to area in his wheelchair, and cleaned up the used orning cares. NA-H washed ing the soiled linens in the in 10/15/15, at 1:37 p.m. build have washed her hands aloves when caring for R31. Of wound care on 10/15/15, at nurse (RN)-B applied a pair and assisted R14 off a beleted perineal cares using the removed the old dressing RN-B did not perform ange her gloves after care prior to removing the buttock. RN-B stated the old to be completely soiled with	F 44	41		
F 441	room to help with an was just nervous." During observation of at 6:28 a.m. R31 was assistant (NA)-H wit R31's incontinence prompleted perineal of incontinence pad. Note that is gloves and assisted placing a mechanical lift to transplace that is mechanical lift to transplace the perineal of R31 to the commons returned to his room supplies from his more thands after place soiled utility closet. When interviewed on NA-H stated she should after removing her gloves bedpan. RN-B complete perineal of disposable gloves bedpan. RN-B complete perineal disposable gloves bedpan. RN-B complete gloved hands, the from R14's buttock. The performing perineal dressing from R14's dressing appeared to feces, and the nursing the sing appeared to feces.	other resident, "I know that. I of morning cares on 10/15/15, is being assisted by nursing hadressing. NA-H removed bad with gloved hands, cares and applied a new la-H removed her soiled R31 to turn onto his side, all lift sling underneath of him. In the side wash her hands after which were used to lares for R31. NA-H assisted is area in his wheelchair, and cleaned up the used bring cares. NA-H washed ling the soiled linens in the line 10/15/15, at 1:37 p.m. build have washed her hands loves when caring for R31. In wound care on 10/15/15, at nurse (RN)-B applied a pair is and assisted R14 off a loleted perineal cares using the removed the old dressing RN-B did not perform large her gloves after care prior to removing the buttock. RN-B stated the old	F 4	41		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SU COMPLET	
		245360	B. WING _			C 10/20	/2015
	ROVIDER OR SUPPLIER	Y OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP C 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	ODE	10/20/	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIA	-	(X5) COMPLETION DATE
F 441	RN-B proceeded to no buttock, and prepare applied to the wound RN-B removed the gl room to retrieve a difficulty was applied to R14's her hands after remoon During interview on 1 stated she did not coincluding washing her gloves, but should has A facility Dressing, Didentified staff should any soiled dressings, removing any gloves. During observation of at 8:10 a.m., nursing perineal cares for R5 Afterwards, NA-C to cloth into the bathrood Without washing her pair of gloves, and plated, followed by R57 bathroom, rinsed R57 same gloved hands, could insert them. We same gloves, NA-C go bagged up soiled cloth garbage, and placed After depositing the butility area, NA-C returned and interview on 10 a	hout washing her hands. neasure the wound on R14's a new dressing to be using her gloved hands. oves, and RN-B left the ferent type of dressing which buttock. RN-B did not wash ving her soiled gloves. 0/15/15, at 3:04 p.m. RN-B mplete hand hygiene, r hands, after removing her ve. ry/Clean policy dated 2/2014, use clean gloves to remove and wash their hands after f morning cares on 10/14/15 assistant (NA)-C provided 7 using gloved hands. k the used wash basin and m and removed her gloves. hands, NA-C donned a new aced R57's stockings on his 's shoes. NA-C entered the r's dentures, and, with the held R57's dentures so R57 hile continuing to wear the lave R57 his glasses, then thing, as well as the a new liner in the trash can. lagged items in the soiled larned to R57's room, with	F				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245360	B. WING _			1	C 20/2015
	ROVIDER OR SUPPLIER	Y OF NEW LONDON		10	TREET ADDRESS, CITY, STATE, ZIP CODE 00 GLEN OAKS DRIVE EW LONDON, MN 56273	1 10/	20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 441	Continued From page	e 92	F4	141			
	after cares." NA-C st "changes gloves" and scrubs" to cleanse he	I that she uses "alcohol					
	licensed practical nur "training annually for stated staff actually "I handwashing." LPN- done "before and after	10/16/2015 at 11:06 a.m., se (LPN)-A said all staff had infection control." LPN-A nave to demonstrate A said handwashing was er" resident cares, after lily fluid contact, "even if you					
	RN-C stated hand hy	erformed after perineal care					
	RN-A stated hand hy	10/16/15, at 10:49 a.m. giene should be performed anytime after gloves are					
		re policy dated 10/2010, remove their gloves when n and dry their hands.					
F 520	dated 8/2014, identifical cohol-based hand so water after direct con handling clean or soil removing gloves. Fur gloves were not to be washing.	g / Hand Hygiene policy ed staff should use an anitizing rub or soap and tact with residents, before ed dressings, and after ther, the policy identified used to replace hand	F	520			11/30/15
SS=F							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245360	B. WING		C 10/20/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	10/20/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 520	Continued From page	93	F 52	0		
	assurance committee nursing services; a ph	in a quality assessment and consisting of the director of hysician designated by the other members of the				
	issues with respect to and assurance activit develops and implem	ent and assurance east quarterly to identify which quality assessment ies are necessary; and ents appropriate plans of tified quality deficiencies.				
		rds of such committee h disclosure is related to the ommittee with the				
		y the committee to identify ficiencies will not be used as				
	by: Based on observation review, the facility's quassurance (QA&A) complement, and re-evaddress and identify sinadequate staffing pawere provided with catacordance with their area of activities of daily living	systematic concerns of atterns to ensure residents		A: All residents found to be effected by deficiencies will be reviewed by the Administrator and Director of Nursing, a weekly basis, to assure compliance. The cited areas will be reported in all upcoming Quality Councils. B: QA team will review, evaluate and, needed, recommend improvement processes to ensure other residents a not affected by the same deficient practice.	on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245360	B. WING _			1	C / 20/2015	
NAME OF PI	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	20/2013	
				10	00 GLEN OAKS DRIVE			
BENEDIC	TINE LIVING COMMUN	NITY OF NEW LONDON		N	EW LONDON, MN 56273			
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 520	Continued From pa	ge 94	F 5	520				
F 520	control and facility of (R28, R53, R17, R2) R14, R31, R2, R33 compliance with quantising services and This had the potent the facility. Findings include: The facility did not of care for 2 of 7 reviewed for activiting residents (R17, R2-range of motion (R0, R35, R28) reviewed residents (R14, and ulcers, and for 1 of monitoring skin continuous formulation of the facility did not implement ambulating maintain residents' residents (R57, R3-reviewed for restoration of 7 residents (R24), who were de Refer to F312. The facility did not implement and/or implement a	staffing for 14 of 37 residents 24, R3, R29, R57, R35, R28, and R47) reviewed for ality of care, quality of life, and infection control regulations. Itial to affect all 47 residents in sidents (R28 and R53) es of daily living (ADLs), 4 of 4 degree and R53) es of daily living (ADLs), 4 of 4 degree and R53) and R29) reviewed for OM), 3 of 4 residents (R57, degree and		520	C: Redistribute workload for the QMC position to allot more time for quality improvement and quality assurance. C managers will be involved in monthly of meetings to more quickly identify problem areas. Case managers will meet with rehab aids on weekly basis to discuss changes in ADL performance. Nurse Staffing Coordinator will report to the Committee on progress of open shifts filled. QA action plans will be developed implemented, and re-evaluated for progress according to the regulations. Don will review with monthly CNA/Nurse meetings any items that they wish to be forward to Quality Council. D: All percentage of completion audits be presented to the Quality Council by of the Quality Council Report Form to assist with QA actions and evaluations ensure residents are provided with carnand services in accordance with their assessed needs. Results will be monitored by the Administrator and Director of Nursing	QA em any QA d, se ring will use		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245360	B. WING _			1	20/2015
	ROVIDER OR SUPPLIER	Y OF NEW LONDON		10	TREET ADDRESS, CITY, STATE, ZIP CODE 00 GLEN OAKS DRIVE EW LONDON, MN 56273	1 101	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 520	had recurring, multipl F314.	e 95 in actual harm for F53 who e pressure ulcers. Refer to onsistently provide range of	f f s	520			
	motion services for 4 R3 and R29) in the services for 4 R3 and R29) in the services for 4 R3 and R29) in the services for the facility did not improgram to include control and analysis transmission to other addition, the facility did was completed to reconfection for 4 of 6 resistant facility did not improgram to include control and analysis transmission to other addition, the facility did not improgram to include the facility did not improgram t	of 4 residents (R17, R24, ample reviewed for ervices. plement an infection control posistent monitoring, of infections to reduce the residents in the facility. In id not ensure handwashing duce the potential spread of sidents (R24, R31, R14, ere observed during the					
	ensure the assessed provided pressure ul activities of daily livin nursing. Even though were expressed by fastaff about resident of	ovide sufficient staffing to needs and services were cers, assistance with g (ADL's), and restorative lack of staffing concerns amily members and facility ares and treatments were or completed timely. Refer					
	administrator, director registered nurse (RN of the facilities quality RN-A stated the QA didentified the followin timely completion of the same administratory directors and the same administrator, director registered nurse (RN of the same administratory, director registered nurse (RN of the same administratory) director registered nurse (RN of t	d appropriate antipsychotic					

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

PRINTED: 12/01/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245360	B. WING _			C 10/20/2015	
	ROVIDER OR SUPPLIER	Y OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIF 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	CODE	10/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		DATE	TION
F 520	facility, including bath range of motion, preswere a result of the sRN-A further stated, facility accepted since those residents "that past." In addition, RN keep taking admission to take care of them.' cause" of most of our In continuing the interpressure ulcers, RN-have risen since the RN-A further stated, the pressure ulcers. committee determine needed, the DON state comprehensive assembly a made it easier. Although the facility for pressure ulcers, restormotion, infection contables, the facility rational related to inadequation failed to initiate action assurance process to independent of staffin Review of the facility Quality Assessment a review/revised date 2	arly all" of the issues in the hing, restorative nursing, sure ulcers, and ADL's, taffing issue at the facility. The only new admissions the expetember 1, 2015, were had been in the facility in the N-A stated, we don't want to ms if we "don't have the staff" RN-A also said, the "root issues, "is staffing." Tryiew, when asked about A stated pressure ulcers surveyors arrived on site. I'we knew about a couple" of When asked if the the QA d an action plan was ted, "If we had a ssment," that certainly would acced care area issues with prative nursing, range of trol, and timely completion of onalized the concerns were attention at the staffing. The facility in plans in the quality address these concerns,	F	520			
	systematically by lead included, "There is an						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245360	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, I 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	ZIP CODE	10/20/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE I TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 520	the quality of care, quality council monitors and care and services to improvement, determined develops and/or apprimprovement and evaluation plans." The procedure indicator action plans." Customer and trending well as relevant company and trending well as relevant company action plans. Quality Council addressing and trending well as relevant company action plans. Resident incident action plans. Customer sating Clinical Reimine Review, and	rality of life, customer alatory compliance and improvement." Ited under #1, "The Quality systematically evaluates identify opportunities for ine the potential root cause, oves action plans to create aluates the effectiveness of ited under #6, "Through of facility functioning, as parisons when available, the esses at a minimum: ompliance, dent and accidents, or family complaints, trol, and pharmacy services,	F	520		

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

PRINTED: 11/20/2015 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION 01 - Main Building 01	(X3) DATE SURVEY COMPLETED	
		245360	B. WING			10/16/2015	
	ROVIDER OR SUPPLIER	UNITY OF NEW LONDON		10	TREET ADDRESS, CITY, STATE, ZIP CODE 00 GLEN OAKS DRIVE IEW LONDON, MN 56273		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	тѕ	K	000			
	FIRE SAFETY						
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT THE PAGE OF THE CM	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS - 2567 FORM WILL BE CATION OF COMPLIANCE.					
	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS H.	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN VITH YOUR VERIFICATION.					1-
	Minnesota Departr Fire Marshal Divisi Benedictine Living was found not in corequirements for p Medicare/Medicaid 483.70(a), Life Safedition of National	d at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 101, Life Safety Code (LSC),					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO:	I THE PLAN OF DR THE FIRE SAFETY			EPOC		
	Health Care Fire In State Fire Marshal						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Facility ID: 00314

Electronically Signed

11/18/2015

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

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

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ST	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(,		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
			245360	B. WING			10/	16/2015
		ROVIDER OR SUPPLIER	UNITY OF NEW LONDON	,	10	FREET ADDRESS, CITY, STATE, ZIP CODE DO GLEN OAKS DRIVE EW LONDON, MN 56273		
	(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
	K 000	445 Minnesota St., St Paul, MN 55101 By email to: Marian.Whitney@s Angela.Kappenma THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO	Suite 145 -5145, or state.mn.us and n@state.mn.us PRRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:	Ķ	000			
		to correct the defice. 2. The actual, or possible and/or responsible for correct the defice.	what has been, or will be, done iency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency					
and the state of t		a 1-story building was construction original building was determined to be of 1993 and addition Service Wing that II(000) construction added to the north determined to be of 1999 and addition 1993 addition that II(000) construction and the 3 additions	Community of New London is with a partial basement. The ructed at 4 different times. The as constructed in 1964 and was of Type II(000) construction. In was added to the south of the was determined to be of Type in. In 1996 and addition was of the Service Wing that was of Type II(000) construction. In was added to the south of the was determined to be of Type in. Because the original building is are of the same type cility was surveyed as one					

Facility ID: 00314

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	CENTER	(S FOR MEDICARE	& MEDICAID SERVICES				10 110.	0930-0331
		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION O1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
			245360	B. WING			10/1	6/2015
	NAME OF F	PROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE		
	BENEDIC	TINE LIVING COMM	UNITY OF NEW LONDON			EW LONDON, MN 56273		
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
St. January	K 056 SS=D	system. The facility smoke detection in open to the corrido automatic fire departure and a licensed cap census of 47 at the ce	protected by a fire sprinkler has a fire alarm system with the corridors and spaces in that is monitored for artment notification. The facility acity of 52 beds and had a time of the survey. 142 CFR Subpart 483.70(a) is enced by: 15 AFETY CODE STANDARD 16 Anatic sprinkler system, it is ance with NFPA 13, Standard of Sprinkler Systems, to coverage for all portions of the tem is properly maintained in FPA 25, Standard for the and Maintenance of Protection Systems. It is fully is a reliable, adequate water the electrically connected to the		056	j		11/25/15
		Based on observation found that the autoinstalled and maint NFPA 13 the Stand Sprinkler Systems the sprinkler syste (98) could allow sy	is not met as evidenced by: utions and staff interview, it was matic sprinkler system is not tained in accordance with dard for the Installation of (99). The failure to maintain m in compliance with NFPA 25 estem being place out of service e in the fire protection system			a.Maintenance staff has been educe regarding the necessity to not have different types of sprinkler heads in same compartment. Maintenance inspect all compartments to ensure sprinkler heads are in compliance v K56 as it relates to similar sprinkler heads.	the will with	1 2

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

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	CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OW	D IVO.	0930-0391
	STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION O1 - MAIN BUILDING 01		SURVEY
١			245360	B. WING			10/1	6/2015
İ		ROVIDER OR SUPPLIER	UNITY OF NEW LONDON	STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE		· · ·		
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE ATE	(X5) COMPLETION DATE
	K 056	would affect the refacility. Findings include: On facility tour between 10/16/2015, observe there are two differences.	age 3 ent of an emergency that sidents, visitors and staff of the ween 9:30 AM to 1:30 PM on vations have revealed that tent types of sprinkler head compartment, there are 2	K	056	b.Corrected on or before November 11/25/15. c.Responsibility of Maintenance Dire to correct.		
The state of the s	K 144 SS=F	quick response he type heads located Therapy corridor. This deficient prace Administrator (JI) a NFPA 101 LIFE SA Generators are insunder load for 30 r	ads mixed in with standard in the entrance of the Physical tice was confirmed by the at the time of discovery. AFETY CODE STANDARD pected weekly and exercised ninutes per month in FPA 99. 3.4.4.1.	K	144			11/25/15
						· .		
		Based on docume interview, the facili emergency general requirements of 20	is not met as evidenced by: entation review and staff ty failed to inspect the ator in accordance with the 1000 NFPA 101 - 9.1.3 and 1999 of 6-4.1. The deficient practice residents.			a.Maintenance staff has been educed regarding the importance of maintain monthly documentation for generated testing, which includes minimum Lottest. Maintenance will maintain monogenerator test documentation and wandited monthly for 3 months, then	ining or oad nthly	

Event ID: C6FZ21

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

PRINTED: 11/20/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILANO	OOKILOTION			ING (01 - MAIN BUILDING 01		
		245360	B. WING			10/	16/2015
	PROVIDER OR SUPPLIER CTINE LIVING COMM	UNITY OF NEW LONDON		10	TREET ADDRESS, CITY, STATE, ZIP CODE 00 GLEN OAKS DRIVE EW LONDON, MN 56273		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 144	10/16/2015, documinspection logs No	ween 9:30 AM and 1:30 PM on nentation review of the monthly documentation could be ergency generator of the	K 1	144	quarterly and reported on a quarter basis to the Quality Council. b.Corrected on or before 11/25/15. c.Responsibility of Maintenance Di to correct.		
		tice was confirmed by the at the time of discovery.					53
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Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted November 9, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5360027

Dear Mr. Ingersoll:

The above facility was surveyed on October 12, 2015 through October 20, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5360015. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

Benedictine Living Community Of New London November 9, 2015 Page 2

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fischer, Unit Supervisor at (320)223-7338.

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

Licensing and Certification Program

Health Regulation Division kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	(X3) DATE SURVEY COMPLETED			
		00314		B. WING		10/20/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE ZIP CODE	•
				OAKS DRIVE	, 2.11 0002	
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		ON, MN 5627	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 000	Initial Comments			2 000		
	*****ATTEN	TION*****				
	NH LICENSING CO	ORRECTION ORDER				
	144A.10, this correction pursuant to a survey. found that the deficient herein are not correct not corrected shall be	innesota Statute, section on order has been issue If, upon reinspection, it not or deficiencies cited ed, a fine for each violate assessed in accordances promulgated by rule of the contract of Health.	ed is tion ee			
	corrected requires correquirements of the runumber and MN Rule When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessment	ther a violation has been mpliance with all ule provided at the tag number indicated below several items, failure to be items will be considered, ack of compliance upon the item of multi-part rule went of a fine even if the ing the initial inspection with the ing the initial inspection with the initial initia	v. ed n vill item			
	that may result from norders provided that a	earing on any assessment on-compliance with the written request is made a 15 days of receipt of a for non-compliance.	se			
	receipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electror ure orders consistent woment of Health 14-01, available at e.mn.us/divs/fpc/profinficensing orders are	ith			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Minnesota Department of Health

MANE OF PROVIDER OR BUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS BRIVE NEW LONDON, MIN 95273 PROVIDER OR BUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS BRIVE NEW LONDON, MIN 95273 PROVIDERS PLAN OF CONSECTION NEW LONDON, MIN 95273 PROVIDERS PLAN OF CONSECTION PREFIX TAG PROVI		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
Description Summary Statement or Deficiencies PREFIX TAG Department Summary Statement or Deficiencies PREFIX TAG Department Summary Statement or Deficience PREFIX TAG Department Summary Statement or Deficience PREFIX TAG 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 or complaint H5360015 was completed which was substantiated. Correction orders were issued at State Licensing Rule 4658.0085 Ac 2055. 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 Deficiences" column and replaces the "To Comply" portion of the correction order. This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and			00314	B. WING		10/20/2015	
Department of Health orders will be corrected in the date you relection and the following correction orders are issued. In addition, an investigation of correction relections grave reviewed these orders, and identify the date when they will be correction orders and identify the date when they will be correction orders. Tag numbers have been assigned to glinesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "10 Prefix Tag." The state statute fulled replaced to correction order. This column and replaces the "15 Complian" is listed in the state statute assigned the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors for the correction order. This column and replaces the "15 Correction of the state statute after the statement," This Rule is not met as evidence by." Following the state surveyors of the state evidence by." Following 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	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 October 12-20th, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. In addition, an investigation of complaint H5360015 was completed which was substantiated. Correction orders were issued at State Licensing Rule 4658,0085 A-E 0265. 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 to graph as the state statute 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	BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		3		
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 October 12-20th, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. In addition, an investigation of complaint H580015 was completed which was substantiated. Correction orders were issued at State Licensing Rule 4658.0085 A-E 0265. 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	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE	
	2 000	Department of Health you electronically. Ali is necessary for State enter the word "correct text. You must then in State licensure procedompletion date, the corrected prior to elect Minnesota Department." On October 12-20th, Department's staff, visting following correctic addition, an investigation was completed which Correction orders were Rule 4658.0085 A-E celectronic plan of correviewed these orders they will be completed. Minnesota Department the State Licensing Celectronic plan of corrections of Minnesota Nursing Homes. The assigned tag nuncolumn entitled "ID P statute/rule out of com "Summary Statement and replaces the "To correction order. This findings which are in after the statement, "evidence by." Following are the Suggested Metals and the Suggested Me	orders being submitted to though no plan of correction e Statutes/Rules, please cted" in the box available for dicate in the electronic as, under the heading date your orders will be ctronically submitting to the ent of Health. 2015 surveyors of this sited the above provider and on orders are issued. In the tion of complaint H5360015 was substantiated. The issued at State Licensing 20265. Please indicate in your rection that you have as, and identify the date when direction Orders using numbers have been a state statutes/rules for the refix Tag." The state enpliance is listed in the of Deficiencies" column Comply" portion of the column also includes the violation of the state statute This Rule is not met as ang the surveyors findings ethod of Correction and	2 000			

Minnesota Department of Health STATE FORM

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						SURVEY LETED	
				A. BUILDING: _			
		00314		B. WING		10/	20/2015
NAME OF P	ROVIDER OR SUPPLIER	ST	TREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BENEDIC.	TINE LIVING COMMUNIT	Y OF NEW LONDON		DAKS DRIVE ON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 000	FOURTH COLUMN N "PROVIDER'S PLAN APPLIES TO FEDER THIS WILL APPEAR THERE IS NO REQUE PLAN OF CORRECT MINNESOTA STATE When corrections are date, make a copy of original to the Minnes Division of Compliance	WHICH STATES, OF CORRECTION." THI AL DEFICIENCIES ONLY ON EACH PAGE. WIREMENT TO SUBMIT A TON FOR VIOLATIONS O STATUTES/RULES. Completed, please sign a these orders and return the tota Department of Health, the Monitoring, Licensing at 3333 West Division St,	oF and ne	2 000			
2 255	Assurance Committee A nursing home must assessment and assurance of the administrator, the services, the medical designated by the medical designate	maintain a quality urance committee consisting the director of nursing director or other physicial edical director, and at least of the nursing home's star es directly involved in uality assessment and must identify issues with ity assurance activities are op and implement action to correct identified	t fff,	2 255			

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING			
		00314	B. WING		10/20/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON	OAKS DRIVE	2		
040.15	SLIMMADV ST	ATEMENT OF DEFICIENCIES	DON, MN 5627	PROVIDER'S PLAN OF CORRECTIO	N (VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
2 255	Continued From page	e 3	2 255			
	review, the facility's q assurance (QA&A) complement, and re-evaddress and identify sinadequate staffing payore provided with catacordance with their area of activities of daily living range of motion, restruction and facility staff (R28, R53, R17, R24 R14, R31, R2, R33, acompliance with qualinursing services and	systematic concerns of atterns to ensure residents				
	of care for 2 of 7 residence reviewed for activities residents (R17, R24, range of motion (ROM R35, R28) reviewed for residents (R14, and Fulcers, and for 1 of 3 monitoring skin concern. The facility did not proimplement ambulation maintain residents' ar residents (R57, R35,	s of daily living (ADLs), 4 of 4 R3, and R29) reviewed for M), 3 of 4 residents (R57, for ambulation; 2 of 3 R31) at risk for pressure residents (R2) reviewed for				
	The facility did not pro	ovide bathing assistance for				

Minnesota Department of Health

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Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00314	B. WING		10/20/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON	OAKS DRIVE DON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
2 255	Continued From page	2 4	2 255			
	•	R35, R57, R33, R47 and ndent upon staff for bathing.				
	pressure ulcers from healing of current pre residents (R53, R14) ulcers. This resulted i	onitor, assess, and vise interventions to prevent developing, and to ensure ssure ulcers for 2 of 2 reviewed for pressure n actual harm for F53 who e pressure ulcers. Refer to				
	program to include co trending and analysis transmission to other addition, the facility di was completed to red infection for 4 of 6 res	of infections to reduce the residents in the facility. In id not ensure handwashing uce the potential spread of sidents (R24, R31, R14, ere observed during the				
	ensure the assessed provided pressure uld activities of daily living nursing. Even though were expressed by fa staff about resident care.	ovide sufficient staffing to needs and services were cers, assistance with g (ADL's), and restorative lack of staffing concerns mily members and facility ares and treatments were or completed timely. Refer				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

00314 B. WING 10/20	0/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
BENEDICTINE LIVING COMMUNITY OF NEW LONDON 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCY PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 255 During an interview on 10/20/15, at 9:49 a.m. the administrator, director of nursing (DON), and registered nurse (RN)-A discussed current topics of the facilities quality assurance (DA) committee. RN-A stated the OA committee had recently identified the following issues: staffing, falls, timely completion of clinical assessments, antipsychotic rate and appropriate antipsychotic diagnoses, and culture change. RN-A emphasized that "nearly all" of the issues in the facility, including bathing, restorative nursing, range of motion, pressure ulcers, and ADL's, were a result of the staffing issue at the facility. RN-A further stated, the only new admissions the facility accepted since September 1, 2015, were those residents "that had been in the facility in the past." In addition, RN-A stated, we don't want to keep taking admissions if we "don't have the staff to take care of them." RN-A also said, the "root cause" of most of our issues, "is staffing." In continuing the interview, when asked about pressure ulcers, RN-A stated pressure ulcers have risen since the surveyors arrived on site. RN-A further stated, "we knew about a couple" of the pressure ulcers. When asked if the the QA committee determined an action plan was needed, the DON stated, "if we had a comprehensive assessment," that certainly would have made it easier. Although the facility faced care area issues with pressure ulcers, restorative nursing, range of motion, infection control, and timely completion of ADLs, the facility rationalized the concerns were all related to inadequate staffing. The facility falled to initiate action plans in the quality assurance process to address these concerns, independent of staffing.	

Minnesota Department of Health STATE FORM

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				A. BOILDING			
		00314		B. WING		10/2	20/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		OAKS DRIVE OON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 255	Continued From page	e 6		2 255			
	Quality Assessment a review/revised date 2 "Monitor the provision systematically by lead included, "There is an that assumes responte quality of care, quastisfaction, and regurelated performance in The procedure indicator council monitors and care and services to improvement, determined evelops and/or apprimprovement and evasuch action plans." The procedure indicator tracking and trending well as relevant compounity Council addressing and trending well as relevant compounity counc	n established Quality Cosibility for services relativality of life, customer valuatory compliance and improvement." Ited under #1, "The Quality evaluated a systematically evaluated identify opportunities for interesting the potential root can over action plans to creat a cover a cover action plans to creat a cover	ose, puncil ed to ality es r ause, eate s of				
	The administrator cou designee, medical dir	uld work with the DON of rector, and governing bo rocedures, identify issue	or ody to				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						URVEY ETED	
		00314		B. WING		10/2	0/2015
	ROVIDER OR SUPPLIER	V OF NEW LONDON		RESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	T OF NEW LONDOR	NEW LOND	ON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU .SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
2 255	Continued From page	e 7		2 255			
	In addition, the quality could develop, impler plans to address iden activities of daily living	designee could audit ca / assurance committee nt, and re-evaluate action tified concerns in regar g, pressure ulcers, rangursing, urinary incontine skin conditions, and	on ds to je of				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty	-one				
2 265	MN Rule 4658.0085 Nesident Health Statu	_		2 265			
	policies to guide staff physicians, physician practitioners, and if kn legal representative of member of a resident accident, or death. A nursing services, and attending physician m	assistants, and nurse nown, notify the resident or an interested family 's acute illness, serious t a minimum, the direct the medical director or nust be involved in the policies. The policies ddress at least the	nt's or of an				
		volving the resident whi as the potential for requ n;					
	physical, mental, or percentage example, a deteriorate	nange in the resident's osychosocial status, for ion in health, mental, on either life-threatening complications;					

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00314		B. WING		10	/20/2015
	ROVIDER OR SUPPLIER TINE LIVING COMMUNIT	Y OF NEW LONDON	100 GLEN	RESS, CITY, STA DAKS DRIVE DON, MN 5627			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 265	C. a need to alter example, a need to do of treatment due to accept a new form of the degin and the nurse of the degin and t	treatment significantly, scontinue an existing for diverse consequences, or reatment; transfer or discharge the sing home; or unexpected resident deat is not met as evidence and document review, the residents' families in a sof 1 residents (R2) with a salue that needed physici of 1 residents (R55) whother resident's medication of 1 resident of 1 resident of 1 resident's medication of 1 resident of 1 r	aths. ed an ian no ons MDS) ive ood). ed o o s ated o o o s ated o o o o o o o o o o o o o o o o o o o	2 265			

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE 5 COMPL			E SURVEY IPLETED	
		00314		B. WING		10	0/20/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	, <u> </u>	
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		OAKS DRIVE OON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 265	indication R2's family elevated INR which re involvement and a me adverse effect of the During interview on 1 registered nurse (RN "significantly outside" range and the resider family "should be not "should have been not over 3.5, and nursing documenting the notinotes. When interviewed on RN-C stated the famil INR results for reside significantly out of rar involved with her care "definitely" been notifivalue which required A facility Change in a Status policy dated 9. Nurse Supervisor/Chresident's family or re There is a significa physical, mental, or president's inpairment. During an interview of the supervisor of the significantly or president's family or resident's family or re There is a signification of the significant of the significant of the supervisor of t	coumadin] 2.5 mg nouth] today." was reviewed, there was had been notified of R2 equired a physician edication to correct the coumadin, with a high II 0/19/15, at 1:59 p.m.)-A stated when an INR of their established goant requires Vitamin K, the ified." Further, R2's fam of tified since her INR was a staff should be fication in R2's progress 10/20/15, at 8:35 a.m. ly should be notified of a ints, not just when they a inge. R2's family is very e, and they should have ied of R2's increased IN treatment. Resident's Condition of /2013, identified, "the arge Nurse will notify the presentative [sponsor] int change in the resident	2's NR. is all he hilly has all are like IR r e when hit's ited a.m.	2 265			

Minnesota Department of Health

STATE FORM 6899 C6FZ11 If continuation sheet 10 of 96

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ´	CONSTRUCTION		E SURVEY PLETED
711012711	or connection	IDENTIFICATION TO THE MIDELLA.		A. BUILDING: _			
		00314		B. WING		10	/20/2015
NAME OF P	ROVIDER OR SUPPLIER	ST	REET ADDI	RESS, CITY, STA	ΓE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		DAKS DRIVE	•		
	CUMMADVCT		EW LOND	ON, MN 5627		E CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 265	Continued From page	e 10		2 265			
	not being notified of a R55 in a timely mann wrong medication by was not notified of the	a medication error involving er. R55 was given the staff on 5/2/15, but FM-A e error until two days later "an incidental meeting" wit	on				
	5/4/15, identified the > 5/2/15 - "Resident progrative behaviors not by TMA, resident was 2000 [8 p.m.] medica Passed on to monitor night for any adverse faxed. Supervisor not noted thus far." > 5/3/2015 - "Res [respleasant mood this shoted from med error > 5/4/2015 - "Res ale [occasional] muttering 75% [percent] of breat needed occ ques [sic [encouraged]. No na > 5/4/2015 - "Drt. [da med error over the woof the meds that were	pleasant this shift with no oted. Med error performed is given [another resident's] tions instead of her own. It resident throughout the effects to medications. Mutified. No adverse effects sident] has been in a mift. No SE [side effects] from last evening." It this shift w/occ g noted. Appetite fair, eating akfast, did feed self but given in the self of the self	ID ng				
		was reviewed and lacked ad been notified of the to 5/4/15.					
	registered nurse (RN working when the error RN-C notified the sup	n 10/15/2015, at 8:48 a.m.)-C stated she had been or was reported on 5/2/15. pervisor of the error, and by update him, but added she					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		. ,	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				A. BOILDING			
		00314		B. WING		10/	20/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		OAKS DRIVE OON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATIC		ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETE DATE
2 265	Continued From page	e 11		2 265			
	did not notify R55's F she was aware FM-A care, shrugged her sl [FM-A] should have b When interviewed on the social worker (SV changes" in regard to give FM-A notification been notified of the m question, [FM-A] should During an interview of the director of nursing error occurred, the fa include "timely notific [resident's] family." F FM-A should have be R55 was given the wide A facility Monitoring F Error Involving Admin Medications policy up "All sections of the 'M for Resident Given in completed as soon as notification of physicial SUGGESTED METH The director of nursing and revise policies ar audits related to Notif Resident Health to er conducted to the app a change in health sta	M-A about it. RN-C state was "very involved" in Floulders and stated, "I the been notified sooner." 10/16/2015, at 10:09 a. Wy stated "for any little or R55's care, staff know adding FM-A should have been notified." In 10/16/2015, at 11:56 a g (DON) stated since the cility revised its policy to ation or update of the curther, the DON stated sen "notified right away" rong medications. Resident Post Medication istration of Incorrect bated 6/1/2015, identified ledication Error Report From the Correct Medication is possible; this includes an and family." OD OF CORRECTION: no of the condition of the country of the country of the country of the country of the correct Medication is possible; this includes an and family."	R55's hink Im. to ave ut a.m. a.m. co after n ed, Form t be view is re is sing				
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty-	one-				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00314		B. WING		10	0/20/2015
	ROVIDER OR SUPPLIER	Y OF NEW LONDON	100 GLEN	RESS, CITY, STA DAKS DRIVE DON, MN 5627			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 302	or related disorder tra ALZHEIMER'S DISEA DISORDER TRAININ MN St. Statute 144.6 (a) If a nursing facility Alzheimer's disease or related dis segregated or general care staff and their supervisors care. (b) Areas of required (1) an explanation of related disorders; (2) assistance with ac (3) problem solving wand (4) communication sk (c) The facility shall p written or electronic for training program, the trained, the frequency topics covered.	ASE OR RELATED IG: 503 r serves persons with corders, whether in a all unit, the facility's direct must be trained in dem training include: Alzheimer's disease ar ctivities of daily living; rith challenging behavior	ct nentia nd ors;	2 302			
	by: Based on interview a facility failed to ensur received/Alzheimer's residents and/or inter information regarding	nd document review, the direct-care staff training; and further, the ested family were proves the Alzheimer's training ceived training, how of	at ided ing				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
		00314	B. WING		10/	20/2015
NAME OF D	ROVIDER OR SUPPLIER	•	DDDECC CITY CTA	TE 7/D CODE	1 10/	20/2013
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	TY OF NEW LONDON	NDON, MN 5627	3		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
2 302	Continued From page	e 13	2 302			
		he training provided. This ffect all current residents of amilies.				
	Findings include:					
	Refresher" course, ur the roster. Of the 65 identified as having c January 1, 2015. The	completed the training, as of e facility was unable to aff who completed dementia				
	the facility and contra 9/14/2015, indicated documentation of edu agency staff.] There agreement detailing v	affing Agreement," between act staff agency, signed the agency would provide ucation and training [of was no indication in the what education and training ave, nor indication if agency Alzheimer's training.				
	administrator stated h pool agency staff, cur facility, had the state- training. The administ to ensure our new statraining "before they ladministrator also sai had to provide to resi what dementia training	strator also stated "we need aff" have the dementia hit the floor." The id he did not know the facility dents information about ng staff received. The ht now this information "was				
	registered nurse (RN a computer-based de	/20/2015 at 9:47 a.m.,)-A stated the facility utilized elivery method to complete ng, and as of January 1,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ' '			SURVEY LETED	
		00314		B. WING		10/	20/2015
-	ROVIDER OR SUPPLIER	Y OF NEW LONDON	100 GLEN (RESS, CITY, STA Daks Drive On, Mn 5627			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 302	2015, a new provider roster of staff who con January 1st, but could did not complete train that only "some staff" Alzheimer's/dementia not." In continuing the interinformation about the frequency, the descripresidents "upon requenceded be given to at Alzheimer's/dementiation of the admission information residents, "but it will be SUGGESTED METH. The administrator or opposess to ensure: A completed by both factstaff; and residents at made aware that demistaff, who received training, and a description.	was used. RN-A provimpleted training since d not easily identify stating. RN-A acknowledge have completed the restraining; "many staff have, RN-A believed the Alzheimer's training, the otion, etc, was only give est," and not aware it ill residents. RN-A state training info was "not" mation provided to	ff who ged quire ave to the part its mely rsing re ed to fics.	2 302			
2 560	Plan of Care; Contents Subp. 2. Contents of comprehensive plan of	plan of care. The of care must list measu	rable	2 560			
	long- and short-term	bles to meet the reside goals for medical, nursi nosocial needs that are	ng,				

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 560 Continued From page 15 identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility falled to develop the comprehensive care plan based on assessment for 1 of 4 residents (R56) who utilized bilateral quarter side rails. Findings include: R56's initial Minimum Data Set (MDS), dated 9/22/2015, indicated R56 was cognitively intact, required extensive assistance with bed mobility, and activities of daily living. During the initial facility tour on 10/12/2015 at 1:19 p.m., R56 was observed to have bilateral quarter side rails on his bed. During an interview		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY IPLETED
Description Summary Statement of Deficiencies PREFIX TAG Summary Statement of Deficiencies PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE			00314		B. WING		10	0/20/2015
CX4] ID PREFIX CACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) COMPLETE DEFICIENCY 2 560 Continued From page 15 identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to develop the comprehensive care plan based on assessment for 1 of 4 residents (R56) who utilized bilateral quarter side rails. Findings include: R56's initial Minimum Data Set (MDS), dated 9/22/2015, indicated R56 was cognitively intact, required extensive assistance with bed mobility, and activities of daily living. During the initial facility tour on 10/12/2015 at 1:19 p.m., R56 was observed to have bilateral quarter side rails on his bed. During an interview			TY OF NEW LONDON	100 GLEN	OAKS DRIVE			
identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to develop the comprehensive care plan based on assessment for 1 of 4 residents (R56) who utilized bilateral quarter side rails. Findings include: R56's initial Minimum Data Set (MDS), dated 9/22/2015, indicated R56 was cognitively intact, required extensive assistance with bed mobility, and activities of daily living. During the initial facility tour on 10/12/2015 at 1:19 p.m., R56 was observed to have bilateral quarter side rails on his bed. During an interview	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FL	JLL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	COMPLETE
on 10/14/2015 at 1:45 p.m. R56 stated he used the side rails and "it necessary to have rail up" to aid in turning. R56's initial Siderail Assessment completed on 09/08/2015 indicated there was no need for the side rails. The facility Side Rail Assessment form dated 09/29/2015 indicated "Therapy request res[resident] have side rails to assist with sitting up in bed and transfers in out of bed and turning bed. Res is alert and oriented." Review of R56's care plan, last updated on 09/29/2015 did not identify that R56 utilized any	2 560	identified in the compassessment. The compassessment. The compust include the indiverequired by Minnesot subdivision 14, parage. This MN Requirement by: Based on observation review the facility failst comprehensive care for 1 of 4 residents (Figurater side rails.) Findings include: R56's initial Minimum 9/22/2015, indicated required extensive as and activities of daily. During the initial facilities of daily. During the initial facilities of daily. During the initial facilities of daily. R56's initial Siderail and "it raid in turning. R56's initial Siderail A 09/08/2015 indicated side rails. The facility Side Rail on 1/09/29/2015 indicated res[resident] have side up in bed and transfeled. Res is alert and	prehensive resident mprehensive plan of cavidual abuse prevention a Statutes, section 626 graph (b). In this not met as evidence in, interview, and documed to develop the plan based on assessments (MDS), dated as a section of the plan based on assessments (MDS), dated as a section of the plan based on assessments (MDS), dated as a section of the plan based on assessments (MDS), dated as a section of the plan based on assessments (MDS), dated as a section of the plan based on assessment of the plan based on assessment of the plan based on a section of the plan based on the plan based of the plan bas	n plan 5.557, ced nent nent ral d tact, illity, at ral view sed up" to on the d tting ning	2 560			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DAT			SURVEY ETED	
		00314		B. WING		10/2	20/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		OAKS DRIVE ON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU .SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	During interview on 19 stated the side rails so on the care plan and sheets, which was revitime. The side rails we and the nursing assist SUGGESTED METHODICAL SUGGESTED S	oility, even though R56 I he needed them. 0/19/2015 2:31 p.m. RN hould have been addre the nursing assistant caviewed with RN-A at thiere missing on the care tant care sheets for R50 OD OF CORRECTION ON) or designee, could not policies and proceduevelopment. The DON de training for all nursing	ssed are s e plan 6. : The ares or	2 560			
	ensure compliance.	ality assessment and could perform audits to could perform audits to could perform audits to could perform audits to					
2 565	Plan of Care; Use Subp. 3. Use. A com	Subp. 3 Comprehensive nprehensive plan of care ersonnel involved in the	e	2 565			
	by: Based on observation	t is not met as evidence n, interview and docume ed to ensure staff follow	ent				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		00314	B. WING		10)/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON	EN OAKS DRIVE ONDON, MN 56273			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO ' DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 565	the plan of care for 2 R53) reviewed for act 4 of 4 residents (R17 reviewed for range of residents (R57, R35, ambulation; 2 of 3 resisk for pressure ulce (R2) reviewed for mo Findings include: ADL's R28's 5-day Minimum 8/26/15, identified R2 impairment, and requied complete his ADLs. R28's care plan dated intervention of, "Ambulation of, "Ambula	of 7 residents (R28 and tivities of daily living (ADLs), R24, R3, and R29) motion (ROM), 3 of 4 R28) reviewed for sidents (R14, and R31) at rs, and for 1 of 3 residents nitoring skin concerns. In Data Set (MDS) dated the last had severe cognitive sired extensive assistance to the last had severe cognitive sired extensive si	2 565			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMP	LETED
		00314	B. WING		10/	20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
BENEDIC [*]	TINE LIVING COMMUNIT	Y OF NEW LONDON	N OAKS DRIVE			
		NEW LO	NDON, MN 5627			<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From page	e 18	2 565			
	R53 had moderate concextensive assistance and transferring, and range of motion (ROM to the lower extremition R53's care plan dated intervention of, "Staff [bathroom] as he is a wishes with walker ar follow." An undated Conter-Maple 1 nursi directed staff to, "Aml DAT [distance as tole [and] w/c."	d 9/16/15, identified an offer to walk to and from BR ble and in halls per his nd w/c [wheelchair] to Glenoaks Care ng assistant care sheet b [ambulate] to/from meals trated] w/ [with] walker et				
	restorative aide (RA)- restorative program s RA-B stated, "Therap He's supposed to wal doesn't want to walk I ups." RA-B also state day but I get pulled to shortage of staffing, in During an interview o registered nurse (RN) Care documentation i record, and stated, "T	since 6/17/15 for ambulation. by wanted me to walk him. lk every day. Sometimes he but will always do his pull ed, "I try to walk him every o work on the floor. With the t doesn ' t' get done." In 10/19/15, at 11:59 a.m., b)-A reviewed the Point of in R53's electronic medical The last time [R53] was and in the hallway [by nursing				
	ROM					
	R17's diagnoses, as i	identified on the care plan				

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7,110 1 27,111	or dorate of the transfer of t	IDENTIFICATION NO.	A. BUILDING: _			
		00314	B. WING		10	20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON	I OAKS DRIVE IDON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 565	disease, hemiplegia a annual MDS, dated 8 required extensive as including bed mobility indicated R17 was consistently receiving an interview on 10 restorative aid consistently receiving R24's annual Minimut R17 was consistently receiving and mobility as a care are nursing program. R1 "exercise group," "R0 upper and lower extres "monitor for change" group exercises and activities of daily living. In an interview on 10 registered nurse (RN) managers" were in changers were in changers were in changers and should be monit programs, that they read "should be monit programs are getting she "did not know" if the done consistently. Riprimary restorative aid leaving the facility, rig someone who wants.	uded cerebrovascular and hemiparesis. The //24/2015, indicated R17 sistance with most ADLs, and transfers. The MDS ignitively intact. ated 9/2/2015, identified an and directed a restorative 7's program included an DM (range of motion)" to emities, and direction to in ability to participate in changes in assist with 19. (16/2015 at 9:41 a.m., 1)-A stated the "nurse harge of the restorative eviewed "their own resident" oring progress, as well if the ground or note." RN-A said the programs were getting N-A stated there was one de, and her back up is 11/2015 at 11:32 a.m., 11/2015 at 11:32 a.	2 565			
	required extensive as	4 had intact cognition, sistance of two staff for bed ing, and had functional				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			_		
		00314	B. WING		10/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
BENEDIC:	TINE LIVING COMMUNIT	Y OF NEW LONDON 100 GLEN	OAKS DRIVE		
BENEDIO	THE LIVING COMMONIT	NEW LONE	OON, MN 5627	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 565	Continued From page	20	2 565		
	limitations in range of impairment to upper a R24's care plan, date had impaired function	motion (ROM) with bilateral and lower extremities. d 10/11/15, identified R24 al range of motion with			
	ability to bear weight himself. R24's care pl massage to neck prio	ed a goal to maintain the for transfers and to feed lan included providing r to starting range of motion,			
	extremity, active assist (AAROM) to right upp	per extremity, and bilateral ises with weights, knee			
		wsheets dated tified R24's restorative cumented as completed as			
	> August 2015	0 of 14 opportunities 6 of 13 opportunities 5 of 13 opportunities 1 of 8 opportunities			
	restorative assistant (scheduled to receive times a week, but this RA-A stated, "We have and more to work the to this [restorative proto do the best we can tough. We are pretty states."	n 10/16/15, at 7:59 a.m., RA)-A stated R24 was restorative program, three s wasn't always getting done. we been getting pulled more floor, so we've been getting ogram] less and less. We try but with staffing, it's been short." RA-A stated only two to the restorative program do the program with			
	residents. RA-A state when their exercises	d, "Residents get frustrated and walking aren't done,"			

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AND DIAN OF CORRECTION IN INFER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00314	B. WING		10/20/20	015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON	OAKS DRIVE OON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETE DATE
2 565	Continued From page	21	2 565			
	director of nursing (D	ON).				
	9/19/15, identified R3 impairment, required staff for bed mobility, staff for transfers. Th have bilateral impairm with zero days receiving R3's care plan dated goal to maintain anklerange of motion (PRC (toes upward), plantal with 15 reps each foo upward and hold 30 staff for transfer in the plantal with 15 reps each foo upward and hold 30 staff for transfer in the plantal with 15 reps each foo upward and hold 30 staff for transfer in the plantal with 15 reps each foo upward and hold 30 staff for transfer in the plantal with 15 reps each foo upward and hold 30 staff for transfer in the plantal with 15 reps each foo upward and hold 30 staff for transfer in the plantal with 15 reps each foo upward and hold 30 staff for transfer in the plantal with 15 reps each foo upward and hold 30 staff for transfers. The have bilateral impairm with zero days received in the plantal with zero days received in the plan	a Data Set (MDS) dated to have moderate cognitive extensive assistance of two and total dependence of two e MDS also identified R3 to ment to the lower extremities, and passive ROM. 9/30/15, identified R3 with a example and foot passive DM) including dorsiflexion reflexion (toes downward) to the lower extremes (toes econds, with three reps to to three times weekly as he				
	6/1/15 to 10/20/15, id	rative Flowsheets dated entified R3's received rtunities during this time				
	restorative aide (RA)- restorative services a Restorative Flowshee are not being consiste restorative aides are p with cares due to bein typically scheduled to programs four days a pulled away from ther The nursing assistant do they complete rest	re identified on the tt. The restorative programs ently completed as the pulled to the floor to help ng short staffed. RA-A is work on restorative week, but is consistently in three of the four days. s (NA) are not trained, nor corative programs. Further, incerns had been reported to				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE	SURVEY LETED
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		COM	LETED
		00314	B. WING		10/	20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, STA	ATE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON	LEN OAKS DRIVE LONDON, MN 5627	72		
0/4) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN C	DE CORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From page	e 22	2 565			
	8/29/15, identified R2 memory problems, was	num Data Set (MDS) dated 9 had long and short term as totally dependent on staff d limitations in her ROM on y.				
	"at moderate risk" of one "limited" ROM to her	d 9/4/15, identified R29 was contractures, and had bilateral shoulders. Further, d an intervention of, "PROM kly per therapy				
	from 8/2015 to 10/15/ was to be offered thre Restorative Flowshee received the following > July 2015 > August 2015	et Records identified R29's				
	restorative aide (RA)- getting pulled to the fl restorative programs, had been getting com	10/16/15, at 7:59 a.m., A stated he had been loor to do cares instead of so the restorative programs upleted "less and less." f were trained to complete				
	AMBULATION					
	orders dated 9/16/20 hemiparesis. The qui 9/10/2015, indicated assistance with transi	dentified on physician's 15, included hemiplegia and arterly MDS, dated R57 required extensive ferring, and activities of daily indicated he had intact				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMP	LETED
		00314	B. WING		10/	20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
BENEDIC ³	TINE LIVING COMMUNIT	TY OF NEW LONDON	N OAKS DRIVE			
		NEW LO	NDON, MN 5627			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO' DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From page	e 23	2 565			
	cognition.					
	nursing assistant (NA morning cares. R57 assistive walking dev	n 10/14/2015 at 7:45 a.m. A)-B assisted R57 with used a hemi walker (an rice) to move from the bed wheel chair, while NA-B used 57.				
	stated he participates lately he was only ge	/15/15 at 2:15 p.m., R57 s in a walking program, but tting assistance with walking, vo nursing assistants. R57 not happen on the				
	Form, dated 6/30/201 ambulate with (R57) assistance of 1 with g	ative Nursing Communication 15, indicated R57 was to daily in hallway, using gait belt, and 1 to push the Walk the length of handrail,				
	A review of R57's Re- 7/1/2015 to 10/10/20 ambulated 39 out of 2					
	restorative aide (RA)- restorative ambulatio hallway, and also tha about getting his walk "was getting pulled" to	/16/2015 at 8:18 a.m., -A stated that R57 had a on program to walk in the at R57 "was pretty persistent king done." RA-A stated he to work on the floor, and the were often missed and not ekends.				
		identified on the care plan, included Parkinson's				

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	'		CONSTRUCTION	(X3) DATE S COMPLI	
		00314	В. \	WING		10/2	0/2015
	ROVIDER OR SUPPLIER TINE LIVING COMMUNIT	Y OF NEW LONDON	REET ADDRESS 00 GLEN OAK EW LONDON,	S DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 565	quarterly Minimum Da 6/25/2015, indicated I assistance with transfactivities of daily living R35 had intact cognitions and intact cognitions are plan, updated and intact cognitions are plan, updated and from meals with walker and assist of 1 behind, distance as to During observation or R35 was in her wheel and NA-G pushed R3 dining area. NA-G did In an interview, on 10 NA-G said she did nowalking program. During an interview or rehabilitation aide (RA formal restorative probe walked from her romuch as she could. Falways a willing partice encouragement, but it keep walking. RA-B walking was documer consistently implement of the program walking program "is of that the nursing assis is daily living assis."	nd history of falling. The ata Set (MDS), dated R35 required extensive ferring, bathing and most g. The MDS also indicated on. ated 10/13/2015, identified a, and directed staff to "with FWW &1A (4 wheeled), pull w/c (wheel chair) olerated. a 10/19/2015 at 12:05 p.m prior to the start of lunch 5 from her room into the d not offer to ambulate R3 (19/2015 at 12:08 p.m., t know R35 was on a (10/16/2015 at 11:32 a.m.) A)-B stated R35 "had no gram," but that she was to som to the dining room, as RA-B stated R35 was not sipant, and needed to was important for her to was not sure where R35's inted or if the program was not stated for R35. 19/2015 at 3:01 p.m., -B stated she did not known.	d alk .,, , 5.	565			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE		(X3) DATE SURVEY COMPLETED		
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		00314	B. WING		10/2	0/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON	OAKS DRIVE DON, MN 5627	73		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
2 565	Continued From page walking and restorative getting monitored, and recorded." R28's 5-day MDS date	ve programs were not	2 565			
	extensive assistance, room or corridor, used and had no episodes	, .				
		d 10/9/15, directed staff to from meals, as tolerated ance.				
	transfer into his wheelch himself in his wheelch hallway. An unidentifi offered to push him to breakfast, which he a	. NA-C assisted R28 to Ichair. R28 then propelled nair with his feet into the ed staff walking by R28,				
	restorative aide (RA)- restorative program, I walk him as directed	0/16/15, at 11:28 a.m. A stated R28 was not on the out staff were directed to on the care plan. RA-A ell with a walker for short				
	•	0/16/15, at 12:01 p.m. NA-G walk, and she was not aware d to be walking R28.				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00314	B. WING		10/20/2015
	ROVIDER OR SUPPLIER	Y OF NEW LONDON	EET ADDRESS, CITY, STA GLEN OAKS DRIVE V LONDON, MN 5627		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE COMPLETE THE APPROPRIATE DATE
2 565	9/8/15, identified R14 require extensive ass transfers, toileting and incontinence of urine. R14's care plan dated skin breakdown related incontinence of urine. staff to turn and repost and to provide toiletin when awake, every two needed. On 10/13/15, at 3:42 bed, on her back. R1 receiving the help for open area on her buttwound nurse ordered she was lucky to get hand once at night. During continuous ob 7:01 a.m. to 9:44 a.m. her room. R14 was nown any toileting or incontinent 10/14/15, at 9:40 a.m. (LPN)-C stated R14 swith toileting every two when interviewed on LPN-C stated R14 is and offered toileting enot be acceptable to get the state of t	m Data Set (MDS) dated to be cognitively intact, istance with bed mobility, d was frequently d 9/18/15, identified a risk for ed to pressure, and was The care plan directed sition (R14) every two hour, g on rising, every 1.5 hours to hours at night, and as p.m. R14 observed lying in 4 stated she was not repositioning, and had an cocks. R14 stated the turning every 1.5 hours, but help once during the day servation on 10/14/15, from . R14 was laying in bed in not offered or provided with inence cares for 2 hours en notified of the lack of ce care for R14 on . licensed practical nurse hould have been assisted			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	I \ /	(3) DATE SURVEY COMPLETED		
		00314		B. WING		11)/20/2015
	ROVIDER OR SUPPLIER	TY OF NEW LONDON	100 GLEN	RESS, CITY, STATORINE OAKS DRIVE OON, MN 5627			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 565	2 565 Continued From page 27 On 10/14/15, at 9:44 a.m. LPN-C and NA-D			2 565			
	entered R14's room, right and placed pillo	assisted R14 to turn to w under left side. R14 v sing the bathroom but R	the was				
	When interviewed on 10/14/15, at 1:02 p.m. NA-C stated R14 would be repositioned if the bedpan was used, and believed repositioning should be offered every two hours. When interviewed on 10/14/15, at 1:46 p.m. RN-B stated R14 was frequently incontinent of bowel and bladder, and is to be offered toileting and repositioning. RN-B stated it would not be acceptable to go two hours and 45 minutes without offering toileting or repositioning, and it should be offered every hour. R31's quarterly MDS dated 9/9/15, indicated severe cognitive impairment required extensive assistance for bed mobility and was at risk for developing a pressure ulcer. R31's care plan dated 9/21/15, indicated R31 to be at risk for skin impairment with interventions including alternating air mattress on bed, cushion in wheelchair, heel boots on when in bed, and elevate feet on a pillow when in bed or recliner.		ie				
			of eting be				
			sive				
			ons shion nd				
	During observation of morning care on 10/15/15, at 6:28 a.m. R31 did not have a pillow under R3's feet. On 10/16/15, at 9:54 a.m. R31 was in bed, with no pillow underneath the feet.		r R3's				
	I .	10/15/15, at 11:05 a.m s to have a pillow unde					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/O	ED:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY IPLETED
		00314		B. WING		1 10	0/20/2015
	ROVIDER OR SUPPLIER	TY OF NEW LONDON	STREET ADDRE	AKS DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 565	feet when in bed to a ulcers. When interviewed on NA-D and NA-C was pillow underneath the When interviewed on RN-C stated (R31) w under the feet when i When interviewed on RN-C stated staff we required on the care communication book under his feet. When interviewed on NA-C stated no pillov R31's feet when he w breakfast, and indical was required. SKIN MONITORING R2's diagnoses, as ic change Minimum Dai included long term (canticoagulants, and wimpaired. R2's care plan, dated focus and included, "to] Coumadin usage. thin and fragile and g bumping into things w The care plan directe [with]/daily cares and for bruising r/t Couma on NA-C country to the care plan directe [with]/daily cares and for bruising r/t Couma	ssist in preventing press 10/16/15, at 9:58 a.m. unaware R31 should have feet when in bed. 10/16/15, at 10:02 a.m as to have a pillow placen bed. 10/20/15, at 9:34 a.m. re informed of the cares sheets, and in the for R31 to have pillows 10/20/15, at 9:40 a.m. whad been placed underwas assisted to bed after the dealer was not aware the dealer was not aware the dealer was severely cognitively as severely cognitively bruises and skir the severely cognitively as severely cognitivel	ave a . ed er r this nt /15, as a elated n is]." w	2 565			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00314		B. WING		10	0/20/2015
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		ON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULI SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From page	29		2 565			
	needed].						
	On 10/12/15, at 7:04 have a bruise on the	a.m. R2 was observed to top of her left hand.)				
	dining room. The top and blue in color with	a.m. R2 was observed in of R2's left hand was bla a bruise extending from approximately 2.5 inches	ack her				
	stated she was not su on the top of her left h "bumped into someth	n 10/14/15, at 8:26 a.m. ure how she got the bruis nand. She may have ing." R2 knew she was o id this was why she bruis	se on a				
	nursing assistant (NA bruise on R2's hand of when she came to wo	10/14/15, at 9:15 a.m. -G) stated she saw the on the morning of 10/12/10 ork. NA-G further stated, and "assumed" R2's bruise.	"I				
	stated she saw the br a.m. on 10/12/15, also NA-H said she asked from, but R2 did not re	0/14/15, at 9:17 a.m. NA ruise on R2's hand at 6:0 o when NA-H came to wo R2 what the bruise was ecall where the bruise ca, "I did not report the bru	0 ork. ame				
	licensed practical nur- "not aware" R2 had a hand. LPN-B also sta "yesterday" (10/13/15 bruise on top of R2's	10/14/15, at 9:28 a.m. se (LPN)-B stated, she we bruise on the top of her ated she took care of R2 (), too, but did not see the hand. In addition, LPN-E reported" the bruise to recognition.	left e 3				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						SURVEY LETED	
		00314		B. WING		10	20/2015
	ROVIDER OR SUPPLIER	Y OF NEW LONDON	100 GLEN	RESS, CITY, STA DAKS DRIVE DON, MN 5627			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 565	and the "should have would measure the bit treatment sheet to me A progress note dated indicated R2's bruise bruise was noted on tweekend, when aske stated, 'I bump my ha or the EZ stand, its noturn yellow around the [every] day." Review of the Facility - Interdisciplinary Tea Care Plans - Compredid not address imple SUGGESTED METH The director of nursin review and revise pol to ensuring the care president is followed. designee could devel	." LPN-B then stated sl ruise and place on the	nn. ne aucet g to nning nd /10, blan. could elated or e staff	2 565			
	of care.	directed by the written					
2 800	Staffing requirements Subpart 1. Staffing re	equirements. A nursing		2 800			
		duty at all times a suffici nursing personnel, inclu-					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00314	B. WING		10/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON	OAKS DRIVE DON, MN 5627	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
2 800	nursing assistants to residents at all nurses in all buildings if more	ensed practical nurses, and meet the needs of the s' stations, on all floors, and than one building is es relief duty, weekends,	2 800		
	by: Based on observation review the facility fails staffing to ensure the services were provide and R14) reviewed for resulted in actual hard facility failed to provide ensure residents receivith activities of daily (R47, R35, R17, R24, R17, R12, R57, R33) facility needing staff a who voiced concerns Further, the facility dinursing, for 4 of 4 res R29) reviewed for ran	t is not met as evidenced a, interview, and document ed to provide sufficent assessed needs and ed for 2 of 2 residents (R53 r pressure ulcers, which m for R53. In addition, the e adequate staffing to eived required assistance living (ADL's) for 13 of 47 a, R57, R33, R28, R53, R40, residents who resided in the essistance for ADL's, and/or of insufficient staffing. d not provide restorative idents (R17, R24, R3 and age of motion. The lack of tital to affect all 47 residents			
	expressed by 1 of 3 fa 5 of 22 employees, (L and housekeeping as	of staffing concerns were amily members (FM-A), and PN-A, NA-D, NA-I, NA-O, sistant (HK)-A, expressed ent cares and treatments not completed timely.			
	Findings include:				
		ollowing morning routine residents (R24) reviewed			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						E SURVEY PLETED	
		00314		B. WING		10)/20/2015
	ROVIDER OR SUPPLIER	Y OF NEW LONDON	100 GLEN (RESS, CITY, STA DAKS DRIVE ON, MN 5627			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 800	ambulation services of R28, R53 and R57) roursing. Refer to F37 The facility failed to prove for 6 of 7 residents (Fand R24), who were to bathing. Refer to F31 The facility failed to in minimize skin breakd (R53 and R14) review This resulted in actual recurring pressure uld further information. The facility failed to provide to provide to provide the facility failed to provide to provide the facility failed to conecessary services to for 4 of 4 residents (Freviewed in the samplinformation. RESIDENT COMPLATE R40's quarterly Minim 6/30/15, indicated the impairment, and requibathing and supervise grooming, and mobility failed to provide the facility failed to conecessary services to for 4 of 4 residents (Freviewed in the samplinformation).	onsistently provide or of or 4 of 5 residents (R3seviewed for restorative 11 for additional informations and the following assistant R17, R35, R57, R33, R4 dependent upon staff for 2 for additional informations own for 2 of 2 residents and for pressure ulcers all harm for R53, who have seen and the formation of the formation on the formation on the formation of	ation. ace 47 or or or otion. to s . ad e with of 2 leting ation. tion urther ated tive e with ,	2 800			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00314		B. WING		10	0/20/2015
	ROVIDER OR SUPPLIER	Y OF NEW LONDON	100 GLEN	RESS, CITY, STAT			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI	JLL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 800	stated the facility did aide, and she was su twice a week, however she did not recieve his scheduled for it, and week since she had ribathing. R17's annual MDS daresident had no cognextensive assistance mobility, and most action of the composition of the comp	not have a consistent be prosed to be getting a er, due to the lack of stater bath when she was thought it had been aborecieved assistance with ated 8/24/15, indicated ative impairment, require for transferring, bed tivities of daily living (All 0/12/15, at 7:29 p.m. Resed to get bathed twice been not always get his blot enough people [states bath. R17 stated, "It don't get my bath." In the MDS dated 9/9/15, it had no cognitive irred extensive assistant afterring, and most ADLs of 12/15, at 6:50 p.m. Reded more staff on all sherself having to wait for ng. R12 stated, "I don't staffed, "Is something for help to the bathrough the staffed, "Is something for help to the staff	bath affing, but a not the ed DLs). 17 a paths ff] does ce s. 12 nifts, t like room g that and the ng,	2 800			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	I ' '	(X3) DATE SURVEY COMPLETED	
		00314		B. WING		10/	20/2015
	ROVIDER OR SUPPLIER	Y OF NEW LONDON	100 GLEN	RESS, CITY, STA DAKS DRIVE ON, MN 5627			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 800	Continued From page receiving his schedule did not have enough s	ed bath because the facili	ity	2 800			
	staffed, and feels that have cut back on staf housekeeping had cu	A during interview on n. stated the facility is sh many of the departments	s				
	STAFF COMPLAINTS Licensed practical nurse (LPN)-A during interview on 10/13/15, at 3:29 p.m.stated the facility often used pool nursing agency staff in the mornings to cover shifts, and resident baths were not getting completed due to the lack of staffing. LPN-A stated bath aides were needed to work as NA's (nursing assistant) on the floor, therefore, there was no staff to complete resident baths. LPN-A also stated the restorative aides were often pulled to work on the floor when they should be assisting residents with their restorative program, however, the facility was short staffed so they needed to assist with resident cares, therefore, the restorative programs were not being completed for residents. NA-D during interview on 10/14/15, at 9:18 a.m. stated the facility did not currently have a bath aide, and it was difficult to complete resident baths. NA-D stated when there is a bath aide on the schedule, they, "Often get pulled to work the floor," to assist with resident cares because the						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			l ` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				A. BUILDING: _			
		00314		B. WING		10/	20/2015
NAME OF P	ROVIDER OR SUPPLIER	Ş	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		OAKS DRIVE	2		
0/0.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	NEW LOND	OON, MN 5627	PROVIDER'S PLAN OF CORR	ECTION	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 800	Continued From page	e 35		2 800			
	stated she, "Gets and does not get done, are to the administration of inability to complete reshort staffing. NA-Ass toileting, and repo [redone." NA-I stated by because there was not residents out of bed to grooming does not alto lack of staffing. Housekeeping assists on 10/14/15, at 1:46 per hours had been cut does not alto concerns of not having ensure all cleaning du HK-A stated housekes to ensure deep clean wiping down baseboard	ways get completed relat ant (HK)-A during intervie o.m.stated housekeeping	ng erns he g, ng d ed ed. ew				
	stated R35 would be have time to walk her have enough staff to	v on 10/19/15, at 3:12 p.n able to walk if staff would , however, the facility did ensure the residents were ative care they had been	l not e				
	10/14/15, at 2:40 p.m bath aide and the res reassigned to assist v bit." SC-A stated she voiced concerns to th receiving their baths,	(SC)-A during interview on stated she was aware to torative nursing aide get with resident cares, "Quite was aware residents have facility they were not and the facility was currerain in two additional bath	the e a ad ently				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00314		B. WING		10	0/20/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	,	00.0
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		DAKS DRIVE			
BENEDIO	T		NEW LOND	ON, MN 5627			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIC		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 800	Continued From page	e 36		2 800			
	concerns with lack of (early morning), and to discussing solutions, request to present state available hours. SC-no changes related to lack of staffing, and the staffing of t	and there is an ongoing aff to assist with any ope A stated there were curred taking admissions due ne facility was currently of old nursing staff agency's affing to provide the	en ently to				
	director of nursing (D "doing a lot of intervie and acknowledged th get residents up in the acknowledged staffing facility, and the facility increase," and also havere offering "more so in to work. The DON "flexible scheduling" to looking to post a posi nursing], and were also staff trained and cross	16/2015 at 12:02 p.m., 10 ON) stated they had been wing regarding staffing at it was often difficult "termornings." The DON gramma was concern for the precently had "a wage ad "sign on bonuses" and cholarships" to draw peralso said they were offer or accommodate staff, we tion for "rehab" [restorated to looking to have "more as trained" for both bathing openly stated the facilities an issue."	en I, ito and ople ering vere iive e				
	administrator, directo registered nurse (RN)	n 10/20/15, at 9:49 a.m. r of nursing (DON), and)-A all identiifed they had in the faciltiy and were e issues.	d				
		OD OF CORRECTION: sigee could review staffing					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00314		B. WING		1,	0/20/2015
NAME OF P	ROVIDER OR SUPPLIER	00011	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		3/20/2010
BENEDIC:	TINE LIVING COMMUNIT	Y OF NEW LONDON		OAKS DRIVE			
BENEDIO			NEW LONE	OON, MN 5627			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FL .SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 800	Continued From page	e 37		2 800			
	resident receives the in a timely manner. In or designee could rev	ljustments to ensure ea needed assistance and n addition, the administ riew facility staffing patt promote and recruit ne	d care trator terns				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty	-one				
2 830	MN Rule 4658.0520 S Proper Nursing Care;			2 830			
	receive nursing care a custodial care, and su individual needs and the comprehensive replan of care as described 4658.0405. A nursing of bed as much as powritten order from the	preferences as identification preferences as identification and a sessible in parts 4658.040 g home resident must be assible unless there is a stending physician the in bed or the resident	al and ed in d 0 and oe out a				
	by: Based on observation		ent				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00314		B. WING		10	0/20/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	·	
RENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON	100 GLEN	OAKS DRIVE			
BENEDIO	THE EIVING COMMONT	TOT NEW CONDOR	NEW LOND	ON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU .SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From page	e 38		2 830			
	R2's significant change dated 9/1/15, identified impairment, and had anticoagulant medical R2's care plan dated "At risk for bruising r/t usage. Easily bruises and gets skin tears eas with her w/c [wheelch staff to, "Monitor skin [weekly] bath. Monitor	ge Minimum Data Set (Net R2 had severe cognillong term use of tion (used to thin the blue) 19/14/15, identified R2 was [related to] Coumading and skin is thin and fragasily r/t bumping into thicker]." The care plan direw [with]/daily cares and or for bruising r/t Coumabicious lesions and references.	tive ood). vas, agile ings ected d wkly				
	dining room. The top and blue in color. The	a.m. R2 was observed of R2's left hand was be bruising extended from rist, approximately 2.5	olack				
	During an interview on 10/14/15, at 8:26 a.m. R2 stated she was not sure how she got the bruise on the top of her left hand. She stated she may have "bumped into something," was on a blood thinner, and this was why she bruised "easily." Review of the medical record identified R2's physician orders dated 10/14/15, identified R2 was prescribed coumadin, a medication to prevent strokes by thinning the blood which is monitored with a laboratory value called an international normalized ratio (INR).		ise nay ood				
	8/5/15, identified R2's but her most recent v twice the INR goal for wrote an order, "Adju	on from the physician of INR goal was "2.0 - 3.0 alue was "7.9", more the R2. Further, the physic st coumadin to: Hold 8/10 used to reverse the bloom to the physical results of the bloom to the physical results of the bloom to the physical results of the physician of the physi	0", an cian 5/15;				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 CLEN OAKS DRIVE NEW LONDON, MM SE273 PROVIDERS THAN OF COMMUNITY OF NEW LONDON 100 CLEN OAKS DRIVE NEW LONDON, MM SE273 PROVIDERS THAN OF COMMUNITY OF NEW LONDON, MM SE273 PRECINC 1AG CAN CHARLESCENCE MUST REPORTED BY PULL PRECINCATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 39 thinning effects from coumadin] 2.5 mg [milligrams] p.o. [by mouth] today." When interviewed on 10/14/15, at 9:15 a.m. nursing assistant (NA-G) stated she saw the bruise on R2's hand on the morning of 10/12/15 (2 days ago) when she came to work. NA-G further stated, "1 did not tell anyone" and "assumed" R2's bruise was already reported and being monitored. During interview on 10/14/15, at 9:17 a.m. NA-H stated she first saw the bruise on R2's hand at 6:00 a.m. on 10/12/15. R2 did not recall where the bruise came from, nor did NA-H report it to the nurses, "1 did not report the bruise to anyone." When interviewed on 10/14/15, at 9:28 a.m. licensed practical nurse (LPN-B stated, she was "not aware" R2 bad a bruise on the top of her left hand. LPN-B took care of R2' yesterday" (10/13/15), but did not see the bruise on top of R2's hand. LPN-B stated fine one had reported" the bruise to the, and if any of the nursing assistants noted the bruise, they "should have" reported the bruise. Further, LPN-B stated she would begin monitoring the bruise that day, on 10/14/15. R2 identified a Physician communication fax dated 10/14/15, identified R2's INR (international normalized ratio) goal range was 2.0 to 3.0 and her INR was 5.7 on 10/14/15. In the physician provided orders to hold all doses of coumadin for R2 and recheck her INR on 10/16/15.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY MPLETED		
SUMMARY STATEMENT OF DEPOLENCES DEPOLENCES DEPOLENCE NEW LONDON, MN 65273			00314		B. WING		1	0/20/2015
Description Description	NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 39 thinning effects from coumadin] 2.5 mg [milligrams] p.o. (by mouth) today." When interviewed on 10/14/15, at 9:15 a.m. nursing assistant (NA-G) stated she saw the bruise on R2's hand on the morning of 10/12/15 (2 days ago) when she came to work. NA-G further stated, "I did not tell anyone" and "assumed" R2's bruise was already reported and being monitored. During interview on 10/14/15, at 9:17 a.m. NA-H stated she first saw the bruise on R2's hand at 6:00 a.m. on 10/12/15. R2 did not recall where the bruise came from, nor did NA-H report it to the nurses, "I did not report the bruise to anyone." When interviewed on 10/14/15, at 9:28 a.m. licensed practical nurse (LPN)-B stated, she was "not aware" R2 had a bruise on the top of her left hand. LPN-B took care of R2 "yesterday" (10/13/15), but did not see the bruise on top of R2's hand. LPN-B stated "no one had reported" the bruise to her, and if any of the nursing assistants noted the bruise, they "should have" reported the bruise. Further, LPN-B stated she would begin monitoring the bruise that day, on 10/14/15. R2's medical record identified a physician communication fax dated 10/14/15, identified R2's INR (international normalized ratio) goal range was 2.0 to 3.0; and her INR was 5.7 on 10/14/15. The physician provided orders to hold all doses of coumadin for R2 and recheck her	BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON			3		
thinning effects from coumadin] 2.5 mg [milligrams] p.o. [by mouth] today." When interviewed on 10/14/15, at 9:15 a.m. nursing assistant (NA-G) stated she saw the bruise on R2's hand on the morning of 10/12/15 (2 days ago) when she came to work. NA-G further stated. "I did not tell amyone" and "assumed" R2's bruise was already reported and being monitored. During interview on 10/14/15, at 9:17 a.m. NA-H stated she first saw the bruise on R2's hand at 6:00 a.m. on 10/12/15. R2 did not recall where the bruise came from, nor did NA-H report it to the nurses, "I did not report the bruise to anyone." When interviewed on 10/14/15, at 9:28 a.m. licensed practical nurse (LPN)-B stated, she was "not aware" R2 had a bruise on the top of her left hand. LPN-B took care of R2 "yesterday" (10/13/15), but did not see the bruise on top of R2's hand. LPN-B stated "no one had reported" the bruise to her, and if any of the nursing assistants noted the bruise, they "should have" reported the bruise. Further, LPN-B stated she would begin monitoring the bruise that day, on 10/14/15. R2's medical record identified a physician communication fax dated 10/14/15, identified R2's INR (international normalized ratio) goal range was 2.0 to 3.0; and her INR was 5.7 on 10/14/15. The physician provided orders to hold all doses of coumadin for R2 and recheck her	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FUI		PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE
During interview on 10/16/15, at 7:56 a.m. registered nurse (RN)-A said nursing assistants	2 830	thinning effects from [milligrams] p.o. [by now when interviewed on nursing assistant (NA bruise on R2's hand of (2 days ago) when shouse on R2's hand of (2 days ago) when shouse on R2's bruise being monitored. During interview on 1 stated she first saw the 6:00 a.m. on 10/12/18 the bruise came from the nurses, "I did not When interviewed on licensed practical nur "not aware" R2 had a hand. LPN-B took ca (10/13/15), but did not R2's hand. LPN-B st the bruise to her, and assistants noted the B reported the bruise. It would begin monitoring 10/14/15. R2's medical record in communication fax da R2's INR (international range was 2.0 to 3.0; 10/14/15. The physical doses of coumadir INR on 10/16/15. During interview on 1	coumadin] 2.5 mg nouth] today." 10/14/15, at 9:15 a.m. a-G) stated she saw the on the morning of 10/12/ he came to work. NA-G not tell anyone" and he was already reported 0/14/15, at 9:17 a.m. N/ he bruise on R2's hand a 5. R2 did not recall whe he, nor did NA-H report it for report the bruise to anyone 10/14/15, at 9:28 a.m. he (LPN)-B stated, she had bruise on the top of her here of R2 "yesterday" hat see the bruise on top of ated "no one had report hif any of the nursing bruise, they "should have further, LPN-B stated sing the bruise that day, of the day of th	and A-H at ere to one." was r left of eed" he on	2 830			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMP				
		00314		B. WING		10/2	0/2015
NAME OF PI	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		ON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	"are expected" to repon duty. All NA's recomposed for Resident Cares) without them to report bruisin condition, "My expect assistants would reposed assistants would reposed assistants would reposed assistants would repose observed." RN-A starbeen monitored, and need to contact the promptly to ensure the therapeutic levels of (Although R2 was one of high INR levels, the monitoring R2's bruis remained in therapeutic An undated Expectation Nursing Assistant Carbenonstrated Appropriate Appropriate and the condition are reported but not limed to Chesung SUGGESTED METH director of nursing or revise policies and primplementing recombination of the condition of the	ort new bruises to the nurelive training (Expectation with orientation which tells g and changes in skin ration is that nursing ort all bruises when first ted the bruising should have the bruising should have the coumadin was in the (2.0 to 3.0) for this residence to a solution of the coumadin, and had a hister facility was not consister ing to ensure her INR levitic range for R2. Sons for Resident Cares: The Delivery Practice oriate Care training to the course of the cour	s ave vel nt. ory els ding The nd es. an ed.	2 830			
2 895	MN Rule 4658.0525 S Motion	Subp. 2.B Rehab - Range	e of	2 895			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED		
		00314		B. WING		10	0/20/2015
	PROVIDER OR SUPPLIER	Y OF NEW LONDON	100 GLEN	RESS, CITY, STA DAKS DRIVE DON, MN 5627			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI	JLL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 895	Subp. 2. Range of m that is directed toward through positioning a implemented and ma comprehensive reside of nursing services m development of a nur provides that: B. a resident with receives appropriate increase range of modecrease in range of This MN Requirement by: Based on observation review, the facility fail range of motion servity (R17, R24, R3 and R for restorative nursing Findings include: R17's annual Minimu 8/24/15, identified R1 required extensive as of daily living (ADLs). R17's ADL Function at Care Area Assessme identified R17 had milleg and no movement able to participate as grooming. Further, the worked with therapies occasions.	otion. A supportive production of deforming and range of motion must intained. Based on the ent assessment, the dirust coordinate the sing care plan which a limited range of motion treatment and services tion and to prevent furth motion. It is not met as evidence to consistently provices for 4 of 4 residents 29) in the sample review greatment and services.	ties st be set b	2 895			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00314	B. WING		10/20/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TIME LIVING COMMUNIT	Y OF NEW LONDON 100 GLEN	OAKS DRIVE			
BENEDIC	TINE LIVING COMMUNIT	NEW LONDOR NEW LON	DON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
2 895	Continued From page	: 42	2 895			
	hemiplegia (paralysis cerebrovascular disea intervention of a resto The program included group", and, "ROM [ra and lower extremities directed staff to "moniability to participate in assistance to complete R17's undated Restor identified R17 should range of motion (AAR)	of one side of the body) and ase, and identified an arative nursing program. If attending an "exercise ange of motion]" to his upper and the care plan are for change" in R17's a group exercises and				
	abduction x (times) 10 and; > AAROM (R) elbow is reps and; > AAROM (R) wrist in reps and; > AAROM to (R) finger spread fingers apart for the spread f	oulder in flexion and ach and; in flexion and extension x n flexion and extension x 10 ngers and thumb of left hand				
	sides) lower extremition	stretches to bilateral (both es for 3-5 minutes (could be g upper body activities) and; (R) and (L) hop flexion x 10				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			E SURVEY IPLETED		
		00314		B. WING		11	0/20/2015
	ROVIDER OR SUPPLIER	Y OF NEW LONDON	100 GLEN	RESS, CITY, STAT DAKS DRIVE DON, MN 5627:			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 895	and flexion (kicks) x 1 > Heel cord stretches During observation of NA-A and NA-B assist transfer from the toile mechanical lift. R17 during the transfers, a device using his right R17's Restorative Floth 10/10/2015 were revireceived the following services: > July 11 of 13 op > August 5 of 13 or > September 4 of > October 1 of 4 or > Octobe	(R) and (L) knee extension reps and; is bilaterally for 1 min each 10/14/2015 at 8:22 a sted R17 in his room to the tinto his wheel chair unwas able to bear weigh and hold on to the stan hand and arm. In the stan hand arm. In the	esing a ant adding story and a story and a story a sto	2 895			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					URVEY ETED		
		00314		B. WING		10/2	0/2015
	ROVIDER OR SUPPLIER TINE LIVING COMMUNIT	Y OF NEW LONDON	100 GLEN (RESS, CITY, STA DAKS DRIVE DON, MN 5627			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 895	in a daily "wellness pridepartment staff. RA months she had been because the facility was not getting his recompleted as it shoul stated she knew restrimportant, but there "During interview on 1 physical therapist (PT have a stronger follow are discharged from thad a weekly meeting the resident and the resident would be dis and it "did not matter getting therapy or wawalking program." Thus to "catch things" befunctionality. The PT "were not" consistent was difficult to get and "we still have to take R24's annual Minimum 7/22/15, identified R2 required extensive as mobility and transferr limitations in range of impairment to upper a R24's ADL Function Care Area Assessme identified R24 had hig contractures and limit	aid R17 usually participated and R18 usually participated and storative program do have been. Further, prative programs were was nothing we can do 0/20/2015, at 9:18 a.m. by stated the facility "shew up program after resignerable." In the past, "to with the RN in charge ehab aid" and "every cussed" at least month whether a resident was son a range of motion are PT said it was a way effore a resident lost said restorative program by completed. The PT sid retain qualified staff, care of the residents." In Data Set (MDS) date 4 had intact cognition, sistance of two staff for ing, and had functional function (ROM) with bilated lower extremities. In CAA) dated 7/22/15 or and knee flexion led ROM to bilateral up R24 had a restorative program and Rehabilitation Potent (CAA) dated 7/22/15 or and knee flexion led ROM to bilateral up R24 had a restorative program and restorative program and restorative program and restorative program after the program after residents.	r bed ateral	2 895			

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STATEMENT	T OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00314	B. WING		10/20/2	2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
BENEDIC	BENEDICTINE LIVING COMMUNITY OF NEW LONDON 100 GLEN NEW LONDON			2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE ((X5) COMPLETE DATE
2 895	had impaired function contractures to all ext to maintain the ability and remain able to fe identified intervention provide massage to hange of motion, pass (PROM) to left upper range of motion (AAR extremity, and bilaters with weights, knee excurls. During an observation R24 was sitting in an leaned slightly to the the left, hands were cand lower extremities R24 moved his right a elbow bent. During an interview of stated he was "supportestorative aides three not consistently getting short of help." R24 sido as much as I can, R24's Restorative Floincluded, "Prior to RC [warming gel] massaged decrease tone, then so included, staff were defit upper extremity, A extremity, and 4# we extension kicks, and interview of the state of the stat	al 10/11/15, identified R24 lal range of motion with remities and included a goal to bear weight for transfers ed himself. The care plan is including for staff to lis neck prior to starting sive range of motion extremity, active assistive etoM) to right upper al lower extremity exercises tension, and hamstring an on 10/12/15, at 6:42 p.m., hotorized wheelchair. R24 left, head and neck tilted to close to his body and closed, were bent at the knees. Form occasionally, with right an 10/13/15, at 3:44 p.m. R24 lesed to work" with the et times a week, but it was and done "because they're tated when that happens, "I myself." where the tated 1/23/15, but the tated to provide PROM to lated to provide PROM to lated to provide PROM to lated happens, who irected to provide PROM to lated happens, who is the provide provide provide provide provide provide provide provides and provides a	2 895			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00314		B. WING		10	0/20/2015
	ROVIDER OR SUPPLIER TINE LIVING COMMUNIT	Y OF NEW LONDON	100 GLEN (RESS, CITY, STA DAKS DRIVE DON, MN 5627			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIC		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 895	program had been do follows: > July 2015	owsheets dated tified R24's restorative ocumented as completed ocumented as completed ocumented as completed of 13 opportunities 6 of 13 opportunities 5 of 13 opportunities 1 of 8 opportunities 1 o	e to be ed ceive nd neet etting ing staff s, d s	2 895			
	staff for bed mobility, staff for transfers. Fu	and total dependence our orther, the MDS identified impairments to the lower	of two d R3				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION		E SURVEY IPLETED		
				A. BUILDING: _			
		00314		B. WING		1	0/20/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
			100 GLEN	OAKS DRIVE			
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		ON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 895	Continued From page	e 47		2 895			
	extremities, and recei	ived no days of complet	red				
	PROM including dors	o complete ankle and for iflexion, plantarflexion vel el cord stretches, up to					
	R3's Restorative Flowsheet dated 1/23/15, identified an order for bilateral ankle and foot passive range of motion (PROM) including dorsiflexion (toes upward), plantarflexion (toes downward) 15 reps each foot. Heel cord stretches (toes upward and hold 30 seconds, with three reps to each foot/ankle), once a day Sunday, Tuesday, and Thursday up to three times a week.		es s, ay				
		vsheets dated 6/1/15 - ne ordered PROM had b oleted as follows:	een				
	> June 2015 10 of 13 opportunities > July 2015 9 of 13 opportunities > August 2015 4 of 13 opportunities > September 2015 1 of 13 opportunities > October 2015 1 of 13 opportunities		ties				
	restorative aide (RA)- restorative services a Restorative Flowshee are not being consiste restorative aides are with cares due to bein typically scheduled to programs four days a pulled away from their	et. The restorative progently completed as the pulled to the floor to heling short staffed. RA-A is	p is				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY IPLETED	
				_			
		00314		B. WING		1	0/20/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON	100 GLEN	OAKS DRIVE			
DENEDIO	THE LIVING COMMONT	TOT NEW CONDOR	NEW LOND	ON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 895	Continued From page	e 48		2 895			
	do they complete res	torative programs. Furth					
	R29's quarterly Minimum Data Set (MDS) dated 8/29/15, identified R29 had long and short term memory problems, was totally dependent on staff for her ADLs, and had limitations in her ROM on both sides of her body.						
	R29's care plan dated 9/4/15, identified R29 was "at moderate risk" of contractures, and had "limited" ROM to her bilateral shoulders. Further, the care plan identified an intervention of, "PROM up to 3 X [times] weekly per therapy recommendations." Review of the Restorative Flowsheet Records from 8/2015 to 10/15/15 identified that PROM was to be offered three times a week. The Restorative Flowsheet Records identified R29's received the following PROM: > July 2015		ther,				
			1				
	restorative aide (RA)- getting pulled to the f restorative programs, had been getting com	oleted was becoming	rams				
	10/2010, identified sta	otion Exercises policy da aff should review the car commendations prior to					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		00314		B. WING		10/	20/2015
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		OAKS DRIVE ON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 895	completing ROM for e	each resident, and nd time, type of exercise ong the exercise was	e	2 895			
	The director of nursin inservice staff regardi audit to ensure it is co	ng range of motion and	l				
2 900	Subp. 3. Pressure so comprehensive reside of nursing services m development of a nur provides that: A. a resident who without pressure sore unless condition demonstrate authenticates, that the B. a resident who receives necessary t promote healing, prevnew sores from development.	ent assessment, the direction of the sing care plan which senters the nursing homes does not develop at the individual's clinical es, and a physician ey were unavoidable; and has pressure sores reatment and services to the infection, and previoping.	ector e al nd to vent	2 900			
	This MN Requiremen by:	t is not met as evidenc	ed				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1			(X3) DATE SURVEY COMPLETED	
				A. BUILDING: _			
		00314		B. WING		10/	20/2015
NAME OF PI	ROVIDER OR SUPPLIER	S	TREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		OAKS DRIVE OON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 900	review, the facility failimplement and/ or reviews pressure ulcers from healing of current presidents (R53, R14) ulcers. This resulted in had recurring, multiple findings include: R53 sustained harm with stage 3 (Full thickness fat may be visible but not exposed. Slough obscure the depth of undermining or tunnel left and right heel, and loss of dermis present with a red pink wound pressure ulcer to the monitor and comprehiulcers as they develophysician of the develophysician direction of physician when change of the pressure ulcers assessment of the pressure ulcers assessment of the pressure ulcer treatmed the pressure ulcer treatmed assessment of the pressure ulcer treatmed and the pressure ul	n, interview, and document ed to monitor, assess, and vise interventions to prevedeveloping, and to ensure ssure ulcers for 2 of 2 reviewed for pressure n actual harm for F53 where pressure ulcers. When he developed two s tissue loss. Subcutaneous bone, tendon or muscle is may be present but does tissue loss. May include ling) pressure ulcers to the da stage 2 (partial thicknown ting as a shallow open ulcers).	d ent ee oo	2 900			
	peripheral vascular di	diagnosis including diabet isease, and cerebrovascu iemiparesis (weakness or	ılar				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00314	B. WING		10/	20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, STA	TE, ZIP CODE		
		100 G	LEN OAKS DRIVE			
BENEDIC	TINE LIVING COMMUNIT	TY OF NEW LONDON NEW	LONDON, MN 5627	' 3		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN (OF CORRECTION	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE A		COMPLETE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIE		DATE
					,	
2 900	Continued From page	e 51	2 900			
	one side of the body)	. The MDS also indicated				
		eveloping pressure ulcers,				
		essure ulcers, and there				
	were no pressures ul					
	assessment.	·				
		Care Area Assessment				
		, indicated R53 was, "At risk				
		nd breakdown r/t [related to]				
s/p [status post] [following] CVA /TIA [transient						
ischemic attack] [mini stroke] w/ [with] (L) [left] hemiparesis, Alz [Alzheimer's] dementia,						
		w/ all mobilities and toileting				
		adder incont [incontinence],				
		ate needs effectively at				
	_	of DM [Diabetes Mellitus],				
		cular disease] w/Hx [history]				
] to heels. Admitted [R53]				
	to facility last year wit	th (B) [bilateral] hamstring				
	contractures which in	creases risk for pressure				
		R53's CAA also included,				
		es. Heels intact." The CAA				
		s including; staff to reposition				
		, have the resident wear heel				
	l *	ed, use of an alternating				
	pressure mattress an	monitoring with daily cares.				
	Wilcolonali, and Skill	morntoring with daily cares.				
	R53's most recent au	arterly MDS dated 9/16/15,				
		ued to be at risk for pressure				
		stage two pressure ulcer				
		s of dermis presenting as a				
	shallow open ulcer w	ith a red-pink wound bed				
	,	vas not present on the prior				
	MDS assessment, da	ated 6/17/15.				
	During an observation	n on 10/14/15, at 9:27 a.m.,				
	_	A)-B was assisting R53 with				
		nad a blue heel boot on the				
		ng only a white sock on the				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
		00314	B. WING		10/	20/2015
NAME OF D			DDEGG OITY OTA	TE 710 000E	1 10/	20/2010
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	I E, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON	N OAKS DRIVE NDON, MN 5627	2		
			4DON, WIN 3027			1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From page	e 52	2 900			
	left foot, and both hee R53's bottom sheet of areas of drainage. Note of the removed the sock from the left head she needed to find the sock for R53's left heel was recliner, and was not heel boots were noted which velcroed on the heel was still touching the sock for R53's left heel was still touching the sock for R53's left heel was not heel was still touching the sock for R53's left heel was still touching the R53's left he	els were directly on the bed. In the bed had numerous A-B removed the heel boot and there was a saturated Is lateral heel. NA-B then Im the left foot, which had a Issure ulcer approximately 2 Isounding tissue that had a Isted on the medial left heel. In ever worked with R53, and It is enurse to have the pressure It is observed laying in R53's It is on his left heel. The blue It is observed to be cloth foam boots It is foot and leg, however, the It is given by the boot and pressure was It is defined by the boot and pressure was the boot and pressur				
	(LPN)-B entered R53 with dressings and a the saturated dressing cultured the drainage ulcer. The right heel p to be approximately 2 surrounding tissue the LPN-B stated she wo knew about the press however, she was no ulcer on the left heel at to summon registered R53's pressure ulcers entered R53's room a R53 had a left heel prot aware it was oper right heel pressure ulcersage 3" pressure	a.m. licensed practical nurse 's room per NA-B's request culturette. LPN-B removed g from the right heel and on the right heel pressure pressure ulcer was observed 2-3 cm, beefy red, with at had a pasty white color. The with R53 daily, and sure ulcer on the right heel at aware R53 had a pressure also. LPN-B directed NA-C d nurse (RN)-C to assess so on the heels. RN-C and stated she was aware ressure ulcer, but she was n. RN-C observed R53's cer and identified it as a cer, and stated the right heel however RN-C did not				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI, IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00314		B. WING		10	0/20/2015
NAME OF P	ROVIDER OR SUPPLIER	S	TREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		1	00 GLEN (DAKS DRIVE	,		
BENEDIC.	TINE LIVING COMMUNIT	Y OF NEW LONDON	IEW LOND	ON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From page 53 measure the right heel pressure ulcer. RN-C did measure the left heel pressure ulcer at that time and described it as, "4.5 centimeters [cm] in length with 2 cm open, and 3.7 [cm] width; with 1.2 c.m. actual open area." RN-C was unsure what stage the left heel pressure ulcer was. During interview on 10/14/15, at 10:29 a.m. LPN-B stated the nursing assistants should be informing the licensed staff if they note any resident skin concerns however, LPN-B was not			2 900			
	resident skin concerns however, LPN-B was not aware of R53's left heel pressure ulcer until this morning and stated, "No one had reported it." R53's Skin Risk Assessment with Braden Scale (a tool used to determine pressure ulcer risk) tool		is e				
	dated 6/11/15, identifi of 18, which indicated	ed the resident had a sco	re				
	also indicated the res	ident had no current skin e ulcers at the time of the					
	was titled Observation summary under the C dated 9/4/15, which in	ment completed for R53 n Report, which included a tuarterly Review section indicated R53 continued to)				
	have h/o [history of] p	akdown and included; "Do ressure ulcer to L [left] he hamstrings and knees ar on the heels. Staff to ap	eel, re				
	(B) [bilateral] heel boo open area to his latera	ots while in bedHas had al heel that appeared as a to shoe slipping as he wa	an a				
	The assessment did r the pressure ulcer, an	und in WC [wheelchair]." not indicate which heel ha nd the assessment identifi	ed				
	plan of every 2 hours. indicated R53 had de	to continue the reposition Although the assessment veloped an "open area," erventions developed to	•				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
		00314	B. WING		10/	20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DENEDIO	FINE I NAME COMMUNIT	100 GLEN	OAKS DRIVE			
BENEDIC	TINE LIVING COMMUNIT	NEW LONDON	IDON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From page	e 54	2 900			
	relieve pressure from	R53's heels such as applying heel boots which e vs providing only				
	nursing assistant care on specific cares for replace the blue heel be recliner. The care she regarding repositioning assessed, and there monitor R53's skin for nursing assistant care direction to staff regardindicate R53 had, or vulcers. R53's Resident Progression of the specific care of the staff regarding assistant care direction to staff regarding assistant care as seen as se	was at risk for, pressure ress Notes from 8/13/15-				
	(L) [left] lateral heel we not aware if his shoes perhaps opened up a [centimeters]. After he applied. Instructed stagrippy sock was appliarea." The note did reappearance of the wesurrounding skin, or to ulcer. There was no drainage or discomfor When interviewed on director of nursing (Denote on 8/13/15, should heel had the pressure 8/14/15- "Resident's Its appearance of the western that the stage of the western that the	to have an open area on his vith is [sic] bath. States he is a rub. Appears as blister that and measures 1.1 x 1.1 cm his bath, foam dressing was aff to leave his shoes off and hied. Nursing will monitor not identify the stage, bund bed, wound edges, he depth of the pressure indication if R53 had any rt from the pressure ulcer. 10/16/15, at 8:55 a.m., ON) stated the progress all dhave identified the right				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BENEDICTINE LIVING COMMUNITY OF NEW LONDON (X4) ID SUMMARY STATEMENT OF DEFICIENCIES NEW LONDON, MN 56273 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED C		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY IPLETED
NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY OF NEW LONDON (X4) ID SUMMARY STATEMENT OF DEFICIENCIES NEW LONDON PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TO ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLET TAG CROSS-REFERENCED TO THE APPROPRIATE DATE					_			
BENEDICTINE LIVING COMMUNITY OF NEW LONDON 100 GLEN OAKS DRIVE NEW LONDON, MN 56273 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE			00314		B. WING		10	0/20/2015
NEW LONDON, MN 56273 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
NEW LONDON, MN 56273 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	DENEDIC	TIME LIVING COMMUNIT	TV OF NEW LONDON	100 GLEN	OAKS DRIVE			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDOR	NEW LOND	ON, MN 56273	3		
	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FU		PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 900 Continued From page 55 2 900	2 900	Continued From page 55			2 900			
part of his foot when he is self propelling in w/c [wheelchair]. This appears to be a Stage 2 PU [pressure ulcer]. Foam dressing is clean, dry, and intact. Will have staff not put shoes on either feet and only grippy socks." The note did not identify which heel had the pressure ulcer, however, the Resident progress note also indicated, "Checked (L) heel as well and was slightly red but blanchable." The note did not include a measurement of the red area on the left heel. 8/14/15- "MD updated on PU to (L) heel and left message for daughter." A corresponding fax to MD-A dated 8/14/15 included, "Resident has a stage 2 pressure ulcer to his (L) heel. Measuring 1.1 cm x 1.1 cm. Appears to be from rubbing on his shoes when he would self propel himself in the w/c [wheel chair]. Currently has foam dressing in place to keep wound clean and provide protection. He is going to have grippy socks onuntil the wound is healed. Also will be having blue boots [heel protectors] on when he is in the recliner and in bed." The fax did not include any recommendations from MD-A, nor did the facility receive a response from MD-A verifying the information was received and reviewed. When interviewed on 10/16/15, at 8:55 a.m., DON again stated the pressure ulcer was actually on R53's right heel, and not the left. 8/20/15- "PU to left heel intact." The Progress Note did not include any measurements or description of the pressure ulcer. During interview on 10/16/15, at 8:55 a.m., DON again stated the pressure ulcer was actually on R53's right heel, and not the left.		part of his foot when [wheelchair]. This app [pressure ulcer]. Foai intact. Will have staff and only grippy socks which heel had the progress not (L) heel as well and viblanchable." The note measurement of the 18/14/15- "MD updated message for daughted MD-A dated 8/14/15 stage 2 pressure ulced 1.1 cm x 1.1 cm. App his shoes when he with the word [wheel chair]. dressing in place to k provide protection. He socks onuntil the wind having blue boots [he in the recliner and in include any recomment the facility receive a riverifying the informat reviewed. When intereviewed. When intereviewed in the pressure uright heel, and not the 8/21/15- "Continues to the stafe of the pressure uright heel, and not the 8/21/15- "Continues to the stafe of the pressure uright heel, and not the second the pressure uright heel.	he is self propelling in we pears to be a Stage 2 Pm dressing is clean, dry not put shoes on either is." The note did not ider ressure ulcer, however, ote also indicated, "Cheevas slightly red but a did not include a red area on the left head on PU to (L) heel and ar." A corresponding fax included, "Resident has are to his (L) heel. Measure to his (L) heel. Measure are to his (L) heel mader to his (L) heel mader to his (L) heel mader to his (L) heel measure to be from rubbing ould self propel himself. Currently has foam teep wound clean and are is going to have gripp ound is healed. Also will be protectors on when bed." The fax did not endations from MD-A, not response from MD-A ion was received and reviewed on 10/16/15, at led the pressure ulcer was theel, and not the left. The Progressing weasurements or source ulcer. During 5, at 8:55 a.m., DON againcer was actually on R5 are left.	reu v, and reet ntify the cked I. left to a uring on in left in the is or did t 8:55 vas ss ain 53's				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
		00314	B. WING		10/	20/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
DENEDIO:	FINE I NAME COMMUNIT	100 GL	EN OAKS DRIVE			
BENEDIC	TINE LIVING COMMUNIT	NEW LONDOR	ONDON, MN 5627	73		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From page 56		2 900			
	identify the stage, me the wound bed, woun or the depth of the pre indication if R53 had from the pressure ulc	easurements, appearance of and edges, surrounding skin, essure ulcer. There was no any drainage or discomfort eer.				
	The next Resident Progress Note or assessment regarding R53's pressure ulcer (s) was dated 9/3/15, 13 days later, which indicated R53's pressure ulcer was located on the (R) lateral heel, and measured 0.2 x 0.2 cm, with a small amount of serous drainage. The resident denied any pain, the area was cleansed with normal saline and a foam dressing was applied. The note also included, "Much improvement noted in the healing. ARea [sic] is showing good signs of healing." The note did not identify the stage of the pressure ulcer, appearance of the wound bed,					
	or the depth of the wo	n surrounding, the wound, bund.				
	non-blanchable redde	en [sic] area to (R) lateral 0.5 x 0.5 cm. Skin is intact. Changed dressing to a				
	to] serous [bodily fluic transparent] drainage that hampered the ad Cleansed and dresse reapplied." The note appearance of the wo surrounding skin, or t ulcer. There was no discomfort from the p					
		implications or concerns in is intact. No redness,				

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMF	SURVEY
		00314		B. WING		10.	/20/2015
	ROVIDER OR SUPPLIER	Y OF NEW LONDON	100 GLEN	RESS, CITY, STA OAKS DRIVE OON, MN 5627	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 900	pressure ulcer (s) we progress note, nor wa pressure ulcer had he 9/16/15- "Dressing ch drainage noted on old piece of skin covering infection. New Tegada applied." The note fai appearance of the wo the wound, and failed experiencing any pair 9/19/15- "Resident co (R) lateral heel. No dr layer of skin that is hat Left area OTA [open to cream to heels." The size, the appearance surrounding the wour resident was experient 9/22/15-"Continues wheel. Resident was word came on shift so tenn further assessment of documented. 9/23/15- Indicated R5 swollen than the left, assessment of the prother was healing, no the physician had been the progress no ulcer was 10/4/15, 11 "On last rds [rounds] small dried callous ar	or sores noted." The here not addressed in this as there any indication to taled. anged on Rt [right] heed dressing. Has a loose of the wound, no signs of the end to include the size, bund, the skin surrounding to note if the resident of the motern and apply Euceria note failed to include the size of airly and apply Euceria note failed to include the failed to include the size of the wound, the skin and, and failed to note if the motern and the pressure ulcer was also sirily and the pressure ulcer was also sirily the pressure ulcer to determing the was there any indication.	the the the ing was a to a e off. he the the ser ser and	2 900			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER. IDENTIFICATION NUMB		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00314		B. WING		10	0/20/2015
	ROVIDER OR SUPPLIER	TY OF NEW LONDON	100 GLEN	RESS, CITY, STA DAKS DRIVE DON, MN 5627			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 900	4 cm and is a thicker pigment almost black area. Area is not ope Applied ABT [antibiot covered with Tegade note did not assess the pressure ulcer stage, was, or if R53 was exhocorresponding assistant which were completed referred to in the about 10/5/15- Indicated MI updated on right heel current treatment stated antibiotic ointment are Foam Adhesive dress indication what inform MD-A, nor was there treatment for R53's rimple 10/6/15- "R heel intaction where in the sock." The note failed referring to the right of further assessment appressure ulcer. 10/13/15- "Dressing of ulcer d/t fully saturated yellow with small among dressing with some of with NS [normal saling to outer edges of wound 20% wound 80%. Resider	color. Area measures callous area, with a data in color under the callous, no drainage noted. ic] ointment to area and mr Foam Adhesive." The ulcer to include the what the surrounding experiencing pain. There is essment from the round on 9/25/15, which was ve assessment. D-A and R53's family will pressure ulcer and the ff was using was applying the covering with Tegadesing. There was no nation was shared with any changes to the light heel pressure ulcer	d tissue e was nds as vere e ing erm r. naving on e vas no e e sure ight ted on sed oted ed to f rea.	2 900			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00044	B. WING		10.	00/0045
		00314			10/	20/2015
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON	EN OAKS DRIVE ONDON, MN 5627	' 3		
0(0.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	· ·		E CORRECTION	0/5
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From page	e 59	2 900			
	every 7 days and PRI every shift and chang	N [as needed] to check le daily or PRN if more than MD-A] updated on status of				
	[MD-A] WC [Wound	Received fax order from dostomy and Continence nade, and culture wound."				
	10/14/15- 10:50 a.m. (after observation was completed) "Resident's R heel wound remains					
		erousanguinous fluid. Stage				
		und culture obtained and der. Resident also has a				
	· ·	e. Resident noted to have L				
	lateral heel PU Stage					
	_	.2 cm with 2.5 cm x 2.5 cm				
		und wound bed. Wound				
		in prep applied and covered				
		dressing. Resident currently				
	_	n bed, wears heel boots				
	while in bed, only wea	ars socks with no shoes, has				
		C nurse, culture obtained on				
		be updated on new PU to L				
		erral to Hagen Orthotics for				
		lastic brace to support the				
		proper position] for his heels				
		ent having have [sic] knee				
		and when resident is in bed				
	I	on his lateral heels. This ispected deep tissue injury				
		er also updated on this plan."				
	Although on 10/14/15	i, at 9:49 a.m. R53 was				
	_	ssure ulcers to both the right				
	and left heel, there wa	_				
	· ·	eft heel pressure ulcer until				
	10/14/15, at 10:50 a.r					
	·	d 9/16/15, identified R53 was				

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	CATION NUMBER:	A. BUILDING: _		(X3) DATE SURVEY COMPLETED
00314	l .	B. WING		10/20/2015
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	
BENEDICTINE LIVING COMMUNITY OF NEW LO	ONDON	OAKS DRIVE OON, MN 5627	3	
(X4) ID SUMMARY STATEMENT OF DI PREFIX (EACH DEFICIENCY MUST BE PRE TAG REGULATORY OR LSC IDENTIFYIN	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
at risk for skin impairment and ha skin issues including, "Heels intact plan directed staff to monitor skin and bathing, place heel protectors bed, turn and reposition the reside hours and as needed, lotion heels and to monitor for changes in con update the medical doctor (MD) at though the facility documented Ripressure ulcer on the right heel or facility had not updated the care printerventions to prevent additional from developing, nor did the facility changes to ensure R53 did not copressure on his heels to ensure hourrent pressure ulcers. Review of R53's Treatment Flows 8/1/15-8/31/15, included, "Heel be bed, check for proper placement. undated, handwritten note was accompanied in the facility identified R53 ulcer on his right heel on 8/13/15, treatment ordered/ documented of Flowsheet for August 2015, to the pressure ulcer(s). R53's Treatment Flowsheet, date 9/1/15-9/30/15, included, "Check dressing daily and change weekly [Thursday] til healed. Once a Day [Thursday] til healed. Once a Day [Thursday]." This was implemented undated, handwritten note was accorder which included, "foam dress "Tegaderm Foam Adhesive." R5 Flowsheet also included a handw implemented 9/19/15, which direct heel q [every] NOC [night] notify it make sure Eucerin is applied. The	et." The care with daily cares son while in ent every two so at bedtime, dition/skin, and is needed. Even 53 developed a in 8/13/15, the blan I pressure ulcers ty make any ontinue to have ealing of the sheet, dated bots on while in Every shift." A dided which in recliner also. Is had a pressure there was no on the Treatment e current heel d (R) heel on Thurs on Thu ed on 9/3/15. An dided next to the sing" and 3's Treatment ritten note, cted, "Check R f getting worse &	2 900		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			RVEY	
		00314		B. WING		10/20/	2015
	ROVIDER OR SUPPLIER TINE LIVING COMMUNIT	Y OF NEW LONDON	100 GLEN (RESS, CITY, STA Daks Drive Don, Mn 5627			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE	(X5) COMPLETE DATE
2 900	right heel pressure ulion 9/3/15, 9/5/15, 9/5 open to air on 9/19/18 record indicated the opressure ulcer were norders obtained from R53's Standing Order dated 4/26/14, directed decubitus [pressure ulotify MD of stage 2 of treatment protocol. facility communicated followed up to determ for R53's worsening pnearly two months after right heel pressure ulotify the pressure ulotify the pressure ulotify and the area where his her ulcers or openings on is having pain." During interview on 1 stated during R53's vassessed R53's left hwas not open, however residents right heel pressure ulotify the was not aware the ulcer on the right heel pushe was not aware that ulcer on the right heel aware of R53's right in 10/14/15, when the fastage 3 pressure ulcers.	ed by staff to indicate the cer dressing was changed 15/15, and was then leff. Review of R53's mentioning treatment to Repursing orders, not treat the physician. The signed by the physician and the physician a	ged t dical R53's tment ian ge I roval n the I R3/15, I the D-A day me in re no ere he it the it, as ure s not I	2 900			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00314	B. WING		10/	20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STA	TE, ZIP CODE	-	
		100 G	LEN OAKS DRIVE			
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON NEW	LONDON, MN 5627	'3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From page 62		2 900			
	During interview on 1 stated she was new to had the position prior used to document wo stated she had been documentation. RN-0 any training regarding care, but she was plawhen she did wound educate her on press assessment, and documentation. During a follow-up int p.m. RN-C stated a coprevious RN that held there was no wound assessment and montage.	0/14/15, at 1:50 p.m. RN-C o her role, and the RN who to her had a binder she bund cares, however, RN-C unable to locate the C stated she had not had g pressure ulcer and wound inning on going with RN-B rounds so RN-B could ure ulcer treatment, sumentation. Derview on 10/14/15, at 3:20 all had been placed to the did her position and was told				
	stated she occasiona and indicated staff we (heel protectors) on F when he was in bed of R53's Resident Progrindicated "Dressing of heel this am d/t dress were cleansed with N covered with Tegader wrapped with kerlix [of for security. Heel boowhile in bed/recliner.	ress Note dated 10/18/15, changed to (B) [bilateral] sings coming off. Both heels IS, skin prep applied, and rm Foam dressing and dressing applied to a wound] tts where [sic] both in place No other skin issues to feet still noted to have eschar				
	10/18/15, indicated, '	nt Progress Note dated "Res (resident) noted to ure ulcer to coccyx this am.				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLI		(X2) MULTIPLE	CONSTRUCTION		SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	:	A. BUILDING: _		COMF	PLETED
		00314		B. WING		10	/20/2015
NAME OF P	ROVIDER OR SUPPLIER	S	TREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		1	00 GLEN	OAKS DRIVE			
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON	IEW LONE	ON, MN 5627	3		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE AC	CTION SHOULD BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIEN		DATE
					DEI TOLET		
2 900	Continued From page	e 63		2 900			
	Very first laver of skin	n is off. Measure 1 cm x 2					
		d bed red with no drainage	e.				
	Res peri skin [skin su	_					
	blanchable."						
		ress Note dated 10/19/15,					
	-	had a shower this a.m., b	oth				
		and Lt heel were 50%					
		sings were very foul smelli	ng,				
	drainage was a greer		1				
	was repositioned whi	en old dressings removed	1,				
	T	ol 650 mg [milligrams] at					
		nsed with NS, covered wit	·h				
		esive and wrapped with					
		ssings from falling off. Hee	els				
		Z chair, has edema prese					
	on top of both feet."						
	A Glenoaks Problem/	/Fax Sheet dated 10/19/15	5				
		ed, "1.) Attached are the	J,				
		t's R heel wound [culture].					
		of proteus species and					
		ed to Klebsiella pneumoni	a.				
	_	ture/sensitivity. Resident v					
	be seeing WOC nurs	e tomorrow afternoon for					
	bilateral heels which	are worsening and Stage	II				
		over the weekend. 2.) Which					
		orefer to start resident on?					
	_	MD-A responded with orde	ers				
		g twice daily for 7 days.	•				
		notified the physician of the					
		e ulcer on R53 coccyx, no re reviewed, and the MD					
	· ·	of the measurements of the	he				
		e ulcer to R53's coccyx.					
	, , , , , , , , , , , , , , , , , , ,						
		to MD-A on 10/19/15,					
		tart resident on Juven					
	[protein drink used to	aid with wound healing] 1					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED			
		00314		B. WING		10)/20/2015	
	ROVIDER OR SUPPLIER	Y OF NEW LONDON	100 GLEN (DDRESS, CITY, STATE, ZIP CODE N OAKS DRIVE NDON, MN 56273				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FL LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 900	packet with 8 oz (our meals for open areas Stage II PU to coccy? During interview on 1 stated staff were dire both R53's feet withorecommendation had three weeks because heels." During interview on 1 stated R53, "Has trous should not be wearing stated R53 had press and she believed it stand then developed a heel, "It's been a more [pressure ulcers to be was directed about 3 boots (heel protectors socks on the resident During interview on 1 stated when staff not regarding R53's press should have followed response from the prinot a treatment change completed. DON state know what took place first pressure ulcer to was not employed at "The policies and proprocedure wasn't beit R14's annual MDS date and no cognitive impacts."	ices) of fluid BID between to Bil (bilateral) heels at a R?" MD-A replied with, " 0/19/15, at 9:41 a.m., Noted to put heel boots of ut socks. NA-J stated to been made within the late, "[R53] had sores on both heels, "[R53] had sores on both heels, "and g shoes or socks. NA-Between ulcers on both heels at pressure ulcer to the late that he's had both both heels]." NA-K stated weeks ago to only put its on R53, and not to put its. 0/20/15, at 9:02 a.m. Diffied the physician via factorial to ensure there ge that needed to be ted it was difficult for heels when R53 developed the right heel because the facility. DON stated codures were in place; and followed."	and "Yes." NA-J on this last both IA-K K Is, first, left d she the ut any ON ax staff ve a staff ve a she the she d, The	2 900				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION		E SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING: _		CON	IPLETED
		00314		B. WING			0/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STF	REET ADDI	RESS, CITY, STA	TE, ZIP CODE		
BENEDIC:	TINE LIVING COMMUNIT	TV OF NEW LONDON	0 GLEN C	DAKS DRIVE			
BENEDIC	TIME LIVING COMMONIT	NE NEW LONDOR	W LOND	ON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From page 65			2 900			
	resident was at risk for pressure, and R14 was and repositioned ever included extensive as repositioning routinely needed, monitor for repressure ulcer areas, and side-lying when i wound care was to be ostomy, and continent R14's Physician progindicated R14 had a puttock. No staging, assessment of the presence of the presence of the presence of the progress notes dated	y every two hours and as recurrence of previous, and encourage use of bed in bed. It also identified e completed per wound, nce nurse.					
	lying on her back in b receive the assistance repositioning, and she buttocks. R14 stated should be turning and relieve pressure, how not get repositioned to get help once during	p.m. R14 was observed bed. R14 stated she did not be she needed from staff with the had a "sore" on her I the wound nurse stated she did repositioning often to wever, she stated she does that often, and, "Is lucky to the day and once at night."	th ne				
	voice.	and speaking with a cracking gress notes dated 9/8/15 - ne following:	ng				
	- 9/8/15- "Resident c/	o [complained of] her					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00314		B. WING		10/	/20/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		OAKS DRIVE OON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 900	buttocks where she had There were no measure the "open sores." - 9/14/15- Open area larger than a 50 cent piece 9/16/15- Open area is than a 50 cent piece 9/16/15- Area has in (cm) x 3 cm, almost a to the top and bottom purple 10/5/15- "Appears to near rectum this am [corresponding assess - 10/16/15- "Stage II] Erythema across butt Previous Stage II are appears sealed over measuring 1.5 x 0.6 cm. During continuous ob 10/14/15, from 7:01 a following was observed - 7:01 a.m R14 was - 8:35 a.m. NA-C ask dressed, R14 stated syet. NA-C offered R1 declined, and NA-C le offered toileting or repositions. R14's hand R14 told LPN-C in medications. R14's hand R14 told LPN-C in placed pillows under toileting or repositioned and toile resident was observed repositioned and toile resident was observed.	as some open sores." Irrements or description to buttock appears slig piece. Is currently slightly large Increased to 12 centime Ill open except a few ar In, and surrounding tissu In have more open area In morning]." There was a In morning]." There was a In morning]. There was a In morning to buttoch In morni	ters eas eas e is s no . cks. k the ck. o get et up not her sed, PN-C o s at	2 900			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		\ \ '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00314	B. WING		10/2	0/2015
NAME OF P	ROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
		100 (GLEN OAKS DRIVE			
BENEDIC.	TINE LIVING COMMUNIT	Y OF NEW LONDON	LONDON, MN 562	73		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From page	e 67	2 900			
	repositioning or toileti	na				
	repositioning or tolleti	ng.				
	stated R14 was to be toileting every two hos should not have gone	0/14/15, at 9:40 a.m. LPN-C repositioned and offered urs, and stated the resident 2 hours and 40 minutes o toilet or reposition the				
	entered R14's room a	a.m. LPN-C and NA-D and assisted R14 onto her offered toileting at this time,				
	During a follow up interview on 10/14/15, at 1:09 p.m. R14 stated it is common to put the call light on and wait 15 - 20 minutes for staff assistance, and stated she is frequently incontinent before assistance arrives. R14 also stated staff will walk by when the call light is on, say they will be back, and then turn the call light off without providing assistance.					
	stated R14 is frequen	0/14/15, at 1:46 p.m. RN-B tly incontinent of bowel and staff should be offering R14 itioning every hour.				
	performing a dressing ulcer on R14's buttook dressing and stated the completely soiled with expectation the nursing nursing if a dressing with changed. RN-B assesstated the reddened a 8.5 centimeters (cm), area measured 1.5 x	p.m. RN-B was observed to change to the pressure k. RN-B removed the old ne dressing appeared to be a feces, and it would be her ng assistants would report to was soiled so it could be ssed R14's buttocks and area measured 11.5 cm x and the smaller, deeper red 0.6 cm. She stated the reviously a stage II, but was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00314		B. WING		10	/20/2015
					1 10	72072013
ROVIDER OR SUPPLIER	S	STREET ADD	RESS, CITY, STA	ΓE, ZIP CODE		
TINE LIVING COMMUNIT	Y OF NEW LONDON	100 GLEN C	DAKS DRIVE			
THE EIVING COMMONT	NOT NEW CONDON	NEW LOND	ON, MN 5627	3		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
Continued From page 68			2 900			
now a stage I as it wa	s not open.					
During interview on 10/16/15, at 8:48 a.m. NA-L stated she believed R14 was to be assisted with repositioning every two hours.						
stated she believed R	114 was to be offered					
During interview on 10/16/15, at 10:58 a.m. RN-A stated she believed R14 was to be offered repositioning and toileting every hour when sitting. RN-A stated R14 would refuse toileting and/ or repositioning at times, however, staff should still be offering and encouraging R14 to toilet and reposition to ensure healing of the pressure ulcer.		ting. - till				
of Skin Breakdown da policy to properly ider whose clinical condition impaired skin integrity implement preventation appropriate treatment according to industry policy directed if a resistere was a new deverulcer, staff were to not therapy, and the care care sheets with skin Staff were directed to Ulcer Documentation Documentation form, wound monitoring which the pressure ulcer or area surrounding the	ated 10/10 included, "It is ntify and assess residents ons increase the risk for and pressure ulcers; to be measures; and to prove modalities for wounds standards of care." The sident was admitted with, elopment of a pressure tify the physician, dietary plan and nursing assistate concern would be updated initiate the Initial Pressure form and the Weekly Ulcand were to complete datich included observation the status of the dressing ulcer, presence of possible on sincrease in the status of the dressing ulcer, presence of possible on sincrease in the status of the dressing ulcer, presence of possible or sincrease in the status of the dressing ulcer, presence of possible or sincrease in the status of the dressing ulcer, presence of possible or sincrease in the status of the dressing ulcer, presence of possible or sincrease in the status of the dressing ulcer, presence of possible or sincrease in the status of the dressing ulcer, presence of possible or sincrease in the status of the dressing ulcer, presence of possible or sincrease in the status of the dressing ulcer, presence of possible or sincrease in the status of the dressing ulcer, presence of possible or sincrease in the status of the dressing ulcer, presence of possible or sincrease in the status of the dressing ulcer.	the s ride or /, int ed. re illy of J, ole				
	Continued From page now a stage I as it was During interview on 1 stated she believed R repositioning every two During interview on 1 stated she believed R repositioning and repositional ways incontinent. During interview on 1 stated she believed R repositioning and repositional ways incontinent. During interview on 1 stated she believed R repositioning and toile RN-A stated R14 wou repositioning at times be offering and encoure position to ensure here was a new develor of the reposition of	TINE LIVING COMMUNITY OF NEW LONDON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Continued From page 68 now a stage I as it was not open. During interview on 10/16/15, at 8:48 a.m. NAstated she believed R14 was to be assisted wirepositioning every two hours. During interview on 10/16/15, at 10:28 a.m. NAstated she believed R14 was to be offered toileting and repositioning every hour, and was always incontinent. During interview on 10/16/15, at 10:58 a.m. R1stated she believed R14 was to be offered repositioning and toileting every hour when sitt RN-A stated R14 would refuse toileting and/or repositioning and toileting every hour when sitt RN-A stated R14 would refuse toileting and/or repositioning at times, however, staff should sibe offering and encouraging R14 to toilet and reposition to ensure healing of the pressure ulcustion to ensure healing of the pressure ulcustion to ensure healing of the pressure ulcustion integrity, and pressure ulcers; to implement preventative measures; and to provappropriate treatment modalities for wounds according to industry standards of care." The policy directed if a resident was admitted with, there was a new development of a pressure ulcer, staff were to notify the physician, dietary therapy, and the care plan and nursing assista care sheets with skin concern the ulnitial pressure ulcer Documentation form and the Weekly Ulc Documentation form, and were to complete dawound monitoring which included observation the pressure ulcer or the status of the dressing area surrounding the ulcer, presence of possition area surrounding the ulcer, presence of possitions area.	TINE LIVING COMMUNITY OF NEW LONDON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 68 now a stage I as it was not open. During interview on 10/16/15, at 8:48 a.m. NA-L stated she believed R14 was to be assisted with repositioning every two hours. During interview on 10/16/15, at 10:28 a.m. NA-D stated she believed R14 was to be offered toileting and repositioning every hour, and was always incontinent. During interview on 10/16/15, at 10:58 a.m. RN-A stated she believed R14 was to be offered repositioning and toileting every hour when sitting. RN-A stated R14 would refuse toileting and/ or repositioning at times, however, staff should still be offering and encouraging R14 to toilet and reposition to ensure healing of the pressure ulcer. The facility policy titled, Prevention and Treatment of Skin Breakdown dated 10/10 included, "It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care." The policy directed if a resident was admitted with, or	ROVIDER OR SUPPLIER TINE LIVING COMMUNITY OF NEW LONDON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 68 now a stage I as it was not open. During interview on 10/16/15, at 8:48 a.m. NA-L stated she believed R14 was to be assisted with repositioning every two hours. During interview on 10/16/15, at 10:28 a.m. NA-D stated she believed R14 was to be offered toileting and repositioning every hour, and was always incontinent. During interview on 10/16/15, at 10:58 a.m. RN-A stated she believed R14 was to be offered repositioning and toileting every hour when sitting. RN-A stated R14 would refuse toileting and/ or repositioning at times, however, staff should still be offering and encouraging R14 to toilet and reposition to ensure healing of the pressure ulcer. The facility policy titled, Prevention and Treatment of Skin Breakdown dated 10/10 included, "It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care." The policy directed if a resident was admitted with, or there was a new development of a pressure ulcer, staff were to notify the physician, dietary, therapy, and the care plan and nursing assistant care sheets with skin concern would be updated. Staff were directed to initiate the Initial Pressure Ulcer Documentation form and the Weekly Ulcer Documentation form, and were to complete daily wound monitoring which included observation of the pressure ulcer or the status of the dressing, area surrounding the ulcer, presence of possible	ROVIDER OR SUPPLIER TINE LIVING COMMUNITY OF NEW LONDON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 68 now a stage I as it was not open. During interview on 10/16/15, at 8:48 a.m. NA-L stated she believed R14 was to be assisted with repositioning every two hours. During interview on 10/16/15, at 10:28 a.m. NA-D stated she believed R14 was to be offered toileting and repositioning every hour, and was allways incontinent. During interview on 10/16/15, at 10:58 a.m. RN-A stated she believed R14 was to be offered toileting and repositioning at times, however, staff should still be offering and encouraging R14 to toilet and reposition to ensure healing of the pressure ulcer. The facility policy titled, Prevention and Treatment of Skin Breakdown dated 10/10 included, "It is the policy to properly identify and assess residents whose clinical conditions increase the risk for implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care." The policy directed if a resident was admitted with, or there was a new development of a pressure ulcer, staff were to notify the physician, dietary, therapy, and the care plan and nursing assistant care sheets with skin concern would be updated. Staff were directed to initiate the initial Pressure Ulcer Documentation form and the Weekly Ulcer Documentation form and were to complete daily wound monitoring which included observation of the pressure ulcer or the status of the dressing, area surrounding the ulcer, presence of possible	TOURITION OF THE PROPERTY OF THE LIVING COMMUNITY OF NEW LONDON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PILL RESULATORY OR ISC DENTIFY NIN PROMINTON) COntinued From page 68 Owa stage I as it was not open. During interview on 10/16/15, at 8:48 a.m. NA-L stated she believed R14 was to be assisted with repositioning every two hours. During interview on 10/16/15, at 10:28 a.m. NA-D stated she believed R14 was to be offered toileting and repositioning every hour, and was always incontinent. During interview on 10/16/15, at 10:28 a.m. RN-A stated she believed R14 was to be offered repositioning and toileting every hour, when stiting. RN-A stated she believed R14 was to be offered repositioning and toileting every hour when stiting. RN-A stated she believed R14 was to be offered repositioning and toileting every hour when stiting. RN-A stated she believed R14 was to be offered repositioning and toileting every hour when stiting. RN-A stated she believed R14 was to be offered repositioning and toileting every hour when stiting. RN-A stated she believed R14 was to be offered repositioning and toileting every hour when stiting. RN-A stated she believed R14 was to be offered reposition to ensure healing of the pressure ulcer. The facility policy titled, Prevention and Treatment of Skin Breakdown dated 10/10 included, 'It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modellities for wounds according to industry standards of care." The policy directed if a resident was admitted with, or there was a new development of a pressure ulcer, staff were to notify the physician, dietary, therapy, and the care plan and nursing assistant care sheets with skin concern would be updated. Staff were directed to initiate the Initial Pressure Ulcer Documentation form, and were to complete daily wound monitoring which included obs

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '			SURVEY LETED			
		00314		B. WING		10/	20/2015	
	ROVIDER OR SUPPLIER	Y OF NEW LONDON	100 GLEN (DDRESS, CITY, STATE, ZIP CODE N OAKS DRIVE NDON, MN 56273				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 900	TIME PERIOD FOR O	d to document any charses notes. d Weekly Ulcer Procedure dated 10/10 Ulcer & Weekly Ulcer should be started ntification of pressure pleted at least weekly a policy directed staff to oth, width, depth, draina nneling, wound edges, to notify the physician of gor designee, could re r pressure ulcers to assencessary prevent pressure ulcers to promote healing of director of nursing or uct random audits of the sure appropriate care a nted; to reduce the risk	and age, and of : view sure s e and	2 900				
2 910	•	Subp. 5 A.B Rehab - e. A nursing home mus ogram of bowel and bla		2 910				
	management to reduce unnecessary use of contract of co	ce incontinence and the atheters. Based on the ent assessment, a nurs	e e					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		o. ` ´	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			
		00314	B. WING _		10/	20/2015
	ROVIDER OR SUPPLIER	TY OF NEW LONDON	STREET ADDRESS, CITY 100 GLEN OAKS DRI NEW LONDON, MN (VE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN ((EACH CORRECTIVE CROSS-REFERENCED DEFICE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
2 910	home must ensure the A. a resident who without an indwelling unless the resident's that catheterization was B. a resident who receives appropriate prevent urinary tract	nat: o enters a nursing home catheter is not catheteriz clinical condition indicate	s			
	by: Based on observation review, the facility fail assistance with toilet reviewed for urinary in dependent upon staff. Findings include: R14's annual Minimu 9/8/15, identified R14 require extensive assistance with toilet reviewed for urinary in the facility of the faci	ing for 1 of 2 residents (R ncontinence, and who wa	nt 14)			
	incontinence. R14's Urinary Inconting Assessment (CAA) of the incontinent of uring bathroom. Further, to, "continue toileting rising, Q2H [every two offer during the NOC R14's Bladder Asses	nence Care Area ated 9/8/15, identified R1 e on the way to the he CAA identified staff weng plan of Toilet [sic] upor o hours] during the day, a [night]. sment dated 9/9/15, e "mixed" incontinence, a	ere n and			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	I \ /	(X3) DATE SURVEY COMPLETED	
		00314	B. WING		10/	20/2015
	ROVIDER OR SUPPLIER TINE LIVING COMMUNIT	Y OF NEW LONDON	ET ADDRESS, CITY, STA BLEN OAKS DRIVE LONDON, MN 5627	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 910	every two hours during R14's care plan dated incontinence with intermediate R14 with toileting upon every 1 1/2 hours where at night, and per her result of the particular of	g." Further, the staff to help R14 to the toilet g the day. I 9/18/15, identified a risk for reventions including to help in on rising in the morning, en awake, every two hours request. Servation on 10/14/15, from . R14 was laying in bed in not offered or provided with inence cares for 2 hours en notified of the lack of ce care for R14 on . licensed practical nurse should have been assisted to hours. 0/14/15, at 1:09 p.m. R14 antly put her call light on and 20 minutes to receive help ecoming incontinent before 10/16/15, at 10:58 a.m. and every one hour . Further, RN-A added R14 ered toileting before 2 hours	2 910			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00314		B. WING		10/	/20/2015
	ROVIDER OR SUPPLIER	Y OF NEW LONDON	100 GLEN	RESS, CITY, STA OAKS DRIVE OON, MN 5627			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 910	The director of nursin and revise policies ar monitoring and provise and provide staff educesidents with urinary of nursing or designed to ensure appropriate care is provided.	OD OF CORRECTION g, or designee, could read procedures related to sion of incontinence car cation related to the car incontinence. The direct e could develop an auct and timely incontinence.	eview o re, re of ector dit tool	2 910			
2 915	Subp. 6. Activities of comprehensive reside home must ensure th A. a resident is gi treatments and service abilities in activities of deterioration is a normal the resident's conditional part, activities of daily resident's ability to: (1) bathe, dress, (2) transfer and (3) use the toilet (4) eat; and	iven the appropriate ces to maintain or improfess faily living unless mal or characteristic paon. For purposes of this living includes the and groom; ambulate; ; language, or other	the sing ove	2 915			
	by:	t is not met as evidence, interview and docum					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1101 27.11	or contraction	BERTH ION HOW BERT	A. BUILDING: _			
		00314	B. WING		10/	20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON	LEN OAKS DRIVE LONDON, MN 5627	73		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
	improve and/or maint abilities for 4 of 5 resi	led to provide and nt ambulation services to cain residents' ambulation idents (R57, R35, R28 and eviewed for restorative				
	rindings include: R57's diagnoses, as identified on physician's orders dated 9/16/2015, included intracerebral hemorrhage, hemiplegia and hemiparesis. The quarterly MDS, dated 9/10/2015, indicated R57 required extensive assistance with transferring, bathing and most activities of daily living. The MDS also indicated he had intact cognition. A care area assessment (CAA) for functional status/rehabilitation potential, dated 6/15/2015, indicated R57 required assistance with all ADLs, and was walking with therapy. During observation on 10/14/2015 at 7:45 a.m. nursing assistant (NA)-B assisted R57 with morning cares. R57 used a hemi walker (an assistive walking device) to move from the bed and transfer into his wheel chair, while NA-B used a gait belt to assist R57. In an interview on 10/15/15 at 2:15 p.m., R57 stated he participates in a walking program, but					
	stated the walks "do neekend." A Therapy to Restora Form, dated 6/30/201 ambulate with (R57) of	not happen on the attive Nursing Communication at Indicated R57 was to daily in hallway, using gait belt, and 1 to push the				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00314	B. WING		10/	20/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		100 GLEN	OAKS DRIVE			
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON	NDON, MN 5627	73		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF C	ORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 915	Continued From page	e 74	2 915			
	1-3 times per day.	Walk the length of handrail,				
	Λ DT (physical therap	y) Therapist Progress and				
		dated 8/19/2015, indicated				
		lled services including gait				
	training and neuromu	scular re-education, which				
	improved R57's abiliti					
		on." The discharge plan				
	included "continue wa	•				
	• .	LE (lower extremity) strength				
	maintenance program	II.				
	A review of R57's Res	storative Flowsheets from				
	documented ambulati					
		1 opportunities (no refusals				
	documented)	()				
	•	of 31 opportunities				
		f 30 opportunities				
	October 2 o	of 10 opportunities				
	In an interview on 10/	/16/2015 at 8:18 a.m.,				
	, ,	-A stated that R57 had a				
		n program to walk in the				
		t R57 "was pretty persistent				
		king done." RA-A said R57's				
		, but said it was completed nented. RA-A stated R57				
		is ability, even though some				
		issed. RA-A stated more				
		etting pulled" to work on the				
		ut 50% of the time." RA-A				
	-	retty frustrating" not getting				
		ns done, even though he				
		hab more frequently. RA-A				
		rograms were often missed				
	-	n the weekends. RA-A stated				
	•	bout a residents restorative				
	program, he would as	sk the physical of	I			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	IED	
		00314	B. WING		10/20	10/20/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ATE, ZIP CODE	·		
		100 GLEN	OAKS DRIVE	,			
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON NEW LON	DON, MN 5627	73			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 915	sure who was in char program at the facility In an interview on 10/registered nurse (RN) managers" were in characteristic programs, that they reand "should be monit programs "are getting she "did not know" if the done consistently. RI primary restorative aid	department but was not ge of the restorative (16/2015 at 9:41 a.m.,)-A stated the "nurse harge of the restorative eviewed "their own resident" oring progress, as well if the glone or note." RN-A said the programs were getting N-A stated there was one de, and her back up is job to the program where the program is the p	2 915				
	updated 10/13/2015, disease, weakness, a quarterly Minimum Da 6/25/2015, indicated I assistance with transfliving. The MDS also cognition. The CAA f Status/Rehabilitation indicated she had an mobility and increase recent GI blood. The had Parkinson's, which independence and AE A PT -Therapist Programmer and AE A PT -Therapist Programmer 3/19/20 indicated R57 "has activity tolerance and which allowed for increase."	and history of falling. The lata Set (MDS), dated R35 required extensive ferring, and activities of daily indicated R35 had intact for ADLs Functional Potential, dated 3/25/2015, acute decline in ADLs and diveakness related to a CAA also indicated R35 ch impacted her DLs. Tess & Discharge summary, cated R35 received physical 15 to 5/17/2015. The report shown gains in strength, neuromuscular function reased distances walking rs and ambulation." The					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMP	LETED	
		00314	B. WING		10/	20/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE			
BENEDIC	TINE LIVING COMMUNIT	TY OF NEW LONDON 100 GLE	N OAKS DRIVE				
		NEW LO	NDON, MN 5627	3			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
2 915	Continued From page	e 76	2 915				
	discussed with patien Restorative Nursing p	nt and/or caregivers include program."					
	assistant care sheet,	ss Care Center - Oak nursing printed 10/16/2015, directed om DR (dining room) TID s tolerated."					
	stated R35 "had no for but that she was to be the dining room, as m stated R35 was not a and needed encourage important for her to ke	716/2015 at 11:32 a.m., RA-B ormal restorative program," e walked from her room to nuch as she could. RA-B always a willing participant, gement, but that is was eep walking. RA-B was not lking was documented.					
	In an interview on 10/16/2015 at 9:33 a.m., R35 stated during cares she "walk to the bathroom, I did that yesterday." R35 also said she "sometimes refuses to walk," but the staff has not asked me to walk "for a long time." R35 also said she walked more a couple months ago, "in summer they would take me," but not of late. R35 also said her feet hurt when she walked, "and my balance is off."						
	R35 was seated in he start of lunch, and NA	n 10/19/2015 at 12:05 p.m., er wheel chair, prior to the A-G pushed R35 from her area. NA-G did not offer to					
		0/19/2015 at 12:08 p.m., ot know" R35 was on a					
	stated R57 "has not v	/19/2015 at 3:08 p.m., NA-N walked down the the dining " NA-N stated during his					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	(X3) DATE S	E SURVEY PLETED		
		00314		B. WING		10/2	20/2015
NAME OF P	ROVIDER OR SUPPLIER	, , , , , , , , , , , , , , , , , , , ,	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	1 10/1	0.2010
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		OAKS DRIVE			
	I		NEW LONE	OON, MN 5627			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FL LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 915	Continued From page	e 77		2 915			
	and the past couple of and instead would rate chair. NA-N stated he on a walking program		ed," rheel				
	registered nurse (RN whether R35's walkin documented anywher recent care conference were hurting more, are walk. RN-B also state on the CNA care sheet assistants "are supported to the RNA care support	re." RN-B said since more, R35 expressed her and was refusing more to ed her walking programet", and that the nursing used to document." RN " the walking and resto etting monitored, and	ost legs o ı "is g -B				
	stated R35 "was able take her." NA-O state used to record ambul recorded distances "c said the sheets were "but I have not seen t NA-O said she "did not aware of this. NA-O concern before, wher walked, or their restor would get reminders, then kinda goes by the [walking] is the care sexpected that we do it.	Into walk, if people would the nursing assistant ation in a book, but now on the aide sheets." Note that the aide sheets in the aide sheets in the aide sheet at the facility had this the residents did not get rative programs, then so and it improved for a value wayside." NA-O also sheets, "and it would be it." NA-O also said sheet was time, and not end	d ts v A-O ay, /." were taff while, o said				
	physical therapist (PT	/20/2015 at 9:18 a.m., t) stated the facility "show o up program after resion	ould				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or dorkled hold	IDENTIFICATION NOMBER.	A. BUILDING:		OGWI		
		00314	B. WING		10/	20/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE			
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON	EN OAKS DRIVE ONDON, MN 5627	73			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
2 915	past, "we had a week charge of the residen "every resident would monthly, and it "did now as getting therapy or walking program." for us to "catch things functionality. The PT "were not" consistent difficult to get and retastill have to take care R28's 5-day MDS dathad severe cognitive extensive assistance and toileting. The MI no episodes of rejectiroom or corridor durinand used a wheelchat R28's care plan dated ambulate R28 to and with extensive assistate. A review of R28's Phydated 8/21/15, identifincluded, "[R28] will a staff 100 feet safely wand contact guard as During observation of 10/14/15, at 9:20 a.m mechanical lift to tran R28 then propelled his feet into the hallw walking by R28's roor dining room for break	therapy. The PT said in the ly meeting with the RN in t and the rehab aid" and libe discussed" at least of matter" whether a resident or was on a range of motion. The PT said it was a way before a resident lost said restorative programs ly completed and it was ain qualified staff, but "we of the residents." The 8/26/15, indicated R28 impairment, and required of two staff for transferring DS further indicated R28 had ing cares, did not walk in the lighth assessment period, ir for mobility. In 10/9/15, directed staff to from meals, as tolerated ance. In 10/9/15, directed staff to from meals, as tolerated ance. In 10/9/16, directed walker sist on even surfaces."	2 915				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00314		B. WING		10	/20/2015
	ROVIDER OR SUPPLIER	Y OF NEW LONDON	100 GLEN (RESS, CITY, STA DAKS DRIVE ON, MN 5627			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 915	restorative program, walk him as directed stated R28 walked we distances. During interview on 1 information coordinate been admitted to the past, and would trans HIC-A stated R28 doenow because he progwith his feet. During interview on 1 stated R28 does not nursing was suppose. During interview on 1 stated the former RN restorative nursing or hospitalization on 8/1 working with therapy to see what therapy restated she was not and Therapy Plan of Caredirected staff to ambunursing staff 100 feet. During interview on 1 stated physical therapt to nursing on 8/21/15 return, to walk with standble to find any contonursing, and stated. On 10/16/15, at approximation on 10/16/15, at approximation on 10/16/15, at approximation in 10/16/15, at approxima	A stated R28 was not obut staff were directed to on the care plan. RA-A ell with a walker for short or (HIC)-A stated R28 h facility three times in the ster himself into the reclies not ambulate as much less not ambulate as much less not ambulate as much less not ambulate as not ad to be walking R28. 0/16/15, at 12:01 p.m. Nowalk, and she was not ad to be walking R28. 0/16/15, at 12:14 p.m. How case manager placed Find hold after his most reconstruction of the new Physical edated 8/21/15, which water of the new Physical edated 8/21/15, which was ecommended. HIC-A ware of the new Physical edated 8/21/15, which was elemented at the resident daily work of the new Physical edated 8/21/15, which was elemented at the resident daily work of the new Physical edated 8/21/15, which was elemented at the resident daily not feet. PT-A mmunication of this direction	rt nealth nad e iner. ch lchair NA-G aware HIC-A R28's cent aiting al with T-A ation al A was ection sed.	2 915			
	assisted R28 to walk stated R28 did not ha	approximately 90 feet. we a decline in ambulat rsing was aware of the	PT-A				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3) DA A. BUILDING: CO			
		00314	B. WING _		10	/20/2015
						120/2015
NAME OF P	ROVIDER OR SUPPLIER		REET ADDRESS, CITY,			
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON	0 GLEN OAKS DRI			
	T		EW LONDON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETE DATE
2 915	Continued From page	e 80	2 915			
	recommended to wall current ambulation at	k R28 daily to maintain oility.				
	R53 had moderate co extensive assistance had walked once or to	n and corridor. In addition, 53 had no displays of				
	During an observation on 10/13/15, at 3:47 p.m., R53 was lying in bed, on the left side, with his blankets over head. When approached, R53 rolled slightly onto his back, with both knees bent.					
	identified, "Res [resid diagnoses: hemipare: and HX [history] of ha Requires ext [extensi transfers, ambulation functional ROM to (B) extremities]. He does contractures. Current	have (B) hamstring ly working with OT ') to regain some ability to				
	identified R53 had be on 6/16/15, and, "The restorative. Recomme to meals as tolerated feet and lower legs of to facilitate mobility. Fambulate to meals with ambulation program of the state of the sta	endations include ambulate to stretch hamstrings with n bolster for several minute Resident is on the list to	es			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED		
				_			
		00314		B. WING			0/20/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNI	TY OF NEW LONDON		OAKS DRIVE	2		
(V4) ID	SLIMMARYS	TATEMENT OF DEFICIENCIES	NEW LONE	OON, MN 5627	PROVIDER'S PLAN OF	CORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION		ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 915	Continued From page 81			2 915			
	to] contractures."						
	offer to walk to and f	ed 9/16/15, included, "Si from BR [bathroom] as h his wishes with walker a bllow."	e is				
	nursing assistant car staff to, "Amb [ambu	oaks Care Center-Maple re sheet, undated, direct late] to/from meals DAT d] w/ [with] walker et [an	ed				
	Review of R53's Therapy to Restorative Nursing Communication Form, dated 6/16/15, indicated R53's goals to work towards, were transfers, standing, and mobility, and included, "Ambulate to meals as tolerated. Can stretch hamstrings w/ feet and lower legs on bolster for several minutes to facilitate mobilityEncourage Pt [patient] to participate as much as possible."						
	6/17/15 -10/19/15, ir	rative Flowsheets from dicated the ambulation ompleted as follows:					
		of 13 opportunities of 31 opportunities with	12				
		of 31 opportunities with	3				
		of 30 opportunities with	1				
	October 2015 0 refusals	of 19 opportunities with	2				
	R53's family membe concerned because						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED	
		00314	B. WING		10/	20/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
DENEDIO	FINE LIVING COMMUNIT	TV OF NEW LONDON 100 GLEN	OAKS DRIVE				
BENEDIC	TINE LIVING COMMUNIT	NEW LONDOR	IDON, MN 5627	73			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 915	Continued From page	e 82	2 915				
	He's supposed to be understaffed." FM-A	walked. They are so stated R53 had potential to ctured if staff weren't walking					
	restorative aide (RA)- restorative program s RA-B stated, "Therap He's supposed to wal	since 6/17/15 for ambulation. by wanted me to walk him. lk every day. Sometimes he					
		but will always do his pull ed, "I try to walk him every					
		work on the floor. With the					
	shortage of staffing, it doesn't get done." During an interview on 10/16/15, at 3:05 p.m., certified occupational therapy assistant (COTA) stated, "When we discharge a resident from therapy and recommend restorative nursing, that becomes a nursing program." She would expect the nursing staff to monitor residents receiving restorative program and discuss concerns at the Interdisciplinary Team (IDT) meetings, which the physical therapist and COTA attended.						
	registered nurse (RN) Care documentation record, and stated, "T	on 10/19/15, at 11:59 a.m.,)-A reviewed the Point of in R53's electronic medical The last time [R53] was and in the hallway [by nursing 14/15."					
	revision date 10/10, id be recorded in the rest- the date and time the performed the name and title of performed the process	ange of Motion Exercises dentified the following should sident's medical record: that the exercises were of the individual(s) who dure motion exercise given					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		` ′	CONSTRUCTION	(X3) DATE S	
ANDILAN	or dortheories	IDENTIFICATION NOMBER	ν.	A. BUILDING: _		O O IVII E	LILD
		00314		B. WING		10/2	20/2015
NAME OF PI	ROVIDER OR SUPPLIER	5	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		OAKS DRIVE OON, MN 5627	3		
(VA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	NEW LOND	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETE DATE
2 915	Continued From page 83			2 915			
	- whether the exercise was active or passive - how long the exercise was conducted						
	exercises - any problems or corresident related to the any changes in the participate in the procesif the resident refusereason(s) why and the report other informatics.	e procedure resident's ability to cedure ed the treatment, the	ne				
	The director of nursing and revise policies are activities of daily living education related to a provision of ADLs for nursing or designee of ensure appropriate care.	OD OF CORRECTION: ag or designee, could revi and procedures related to g (ADLs), and provide sta appropriate and timely residents. The director of could develop an audit to are is provided. CORRECTION: Twenty-of	aff f ol to				
21390		Subp. 4 A-I Infection Con	trol	21390			
	Subp. 4. Policies an control program must procedures which pro A. surveillance be collection to identify residents; B. a system for definitions and the subplementations are supplementations.	d procedures. The infect	tion				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00314		B. WING		10/2	20/2015
NAME OF P	ROVIDER OR SUPPLIER	Ş	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		DAKS DRIVE	_		
	CLIMMADY CT		NEW LOND	ON, MN 5627		ION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	Continued From page	e 84		21390			
	reduce risk of transmin D. in-service edu prevention and contro E. a resident hea immunization program defined in part 4658.0 procedures of residenthe prevention and tree F. the developmente employee health policiparactices, including a defined in part 4658.0 G. a system for reproducts which affect disinfectants, antisept incontinence products I. methods for market in the control of the contro	ol; Ith program including an n, a tuberculosis program 0810, and policies and at care practices to assist eatment of infections; ent and implementation of tuberculosis program as 0815; eviewing antibiotic use; eview and evaluation of infection control, such as tics, gloves, and	n as : in f				
	by: Based on observation review, the facility fail control program to incurrending and analysis transmission to other. This had potential to a residing in the facility failed to ensure handwreduce the potential s	In addition, the facility washing was completed to pread of infection for 4 or R14, R57) whose cares the survey.	nt tion ng, ne				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDIEAN	or contribution	IDENTIFICATION NOWE	LIV.	A. BUILDING: _		COMIL	LILD
		00314		B. WING		10/2	20/2015
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DENEDIC:	FINE LIVING COMMUNIT	V OF NEW LONDON	100 GLEN	OAKS DRIVE			
BENEDIC	TINE LIVING COMMUNIT	T OF NEW LONDOR	NEW LOND	ON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21390	Continued From page	e 85		21390			
	2015, identified a flow resident infections. T seven residents expe facility since 6/1/15, winfection being on 9/1 provided spaces to reinformation to track at > Date > Resident Name > Organism/Culture F > Room Number > If Present Upon Adr > Type of Infection (i. [UTI], gastrointestinal > Antibiotic (with start The flowsheet consist name, date of infection however it lacked correspondents.)	7/15. The flowsheet ecord the following and trend infections: Results mission e. urinary tract infection illness [GI], etc.) and, and end dates). tently identified the resion, and type of infection insistent organism ibiotic start and stop dates.	d the dents				
	September 2015, was different flowsheet in infections. The form in the following informat > Resident name > Room > If present upon adm > Organism > Type of infection (i.e. (UTI), gastrointestinal The September 2015 having an infection fo R29 were identified h	included spaces to ider ion: nission e. urinary tract infection	d a htify ts as , and				
	and were located in a	djacent rooms on the Nand R29 were all identi	/laple				

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Minnesot	<u>a Department of Health</u>	n					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	4	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING: _		COMPL	ETED
				_			
				D WING			
		00314		B. WING		10/2	0/2015
NAME OF P	ROVIDER OR SUPPLIER	SI	FREET ADDR	ESS, CITY, STA	TE ZIP CODE		
	1011211 011 001 1 21211			, ,			
BENEDIC'	TINE LIVING COMMUNIT	Y OF NEW LONDON		AKS DRIVE	_		
		N	EW LONDO	ON, MN 5627	3		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
					DEL TOLENOT)		
21390	Continued From page	e 86		21390			
	. •						
	has having a "GI" infe	ection on the report. Furth	er,				
	the report identified th	rree residents had a UTI,					
	two residents had a lo	ower respiratory infection,					
	and one resident had	a skin infection. However	r,				
		tent identification of the					
	•	e infection, symptoms of t	he				
	-	they started or resolved,					
		room for each resident, a	nd				
		date of antibiotics which					
		ch resident. An undated					
	facility September 20						
	identified the docume						
		as presented by the facility	у.				
	The report identified t						
	-	different residents with					
		without complications",					
	however added there	was, "No patterns noted					
	among residents and	staff" despite the resident	s				
	being on the same un	nit, in adjacent rooms, and					
	having the same sym	ptoms on 9/7/15, 9/13/15,					
	and 9/20/15.	-					
	During interview on 1	0/20/15, at 1:05 p.m.					
	•)-A and the director of					
		RN-A was responsible for	, l				
		alysis of the infection data.					
		by RN-A, an analysis is	·				
			,				
		d to the data (i.e. Septemb					
		t) and it is discussed at the					
		rance (QA) meetings. RN					
	•	trending was completed of					
	• •	late they began and cease					
		e tracked on the flowsheet	's				
	provided, and no furth	ner documentation was					
	identified besides wha	at was provided to the					
		ection control program.					
	•	. •					
	A facility policy on the	e infection control program					
	was requested but no						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED		
	00314		B. WING			10/20/2015	
NAME OF P	ROVIDER OR SUPPLIER	00314	STDEET VUU	RESS, CITY, STA	TE ZID CODE	1 10	120/2015
				DAKS DRIVE	ie, zif Gode		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON	NEW LOND	ON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21390	Continued From page	e 87		21390			
	ANTIBIOTIC STEWA	RDSHIP:					
	identified R2, whom runit, completed a "thi after having positive ranalysis / urinary cult the, "Final recheck wisignificant growth." I identify any signs or experiencing to warra or antibiotic treatmen A Facility Event Summed 15/30/15, identified R2 that grew out e-coli [a Ceftin [an antibiotic] 2]	However, the report did symptoms R29 was ant a repeat urine scree	ne potic] / ffied I not ening 15 to ic] i day]				
	stated it was up to the repeat UA/UC should physician decision", a physicians who see reputed from the request a folloor Further, RN-A stated request a follow-up ustreated with antibiotic symptoms. LACK OF HAND HYO During observation of at 7:59 a.m. nursing a perineal cares using the should be repeated by the reputed by the reputed by the reputed by the reputed by the repeated by the repeated by the repeated by the repeated by the reputed by the repeated by the repeated by the repeated by the repeated by the reputed by the r	esidents at the facility of w-up urine screening. most of the physicians rine screening and some despite the lack of GIENE DURING CARE f morning cares on 10/2 assistant (NA)-A complegioved hands. NA-A	e if a did not do ne are S: 14/15, eted				
	cleaned incontinent s	onto the left side in bed tool from R24's buttock s NA-A proceeded to pu	S.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					TE SURVEY MPLETED		
00314		B. WING			10/20/2015		
		00314					0/20/2015
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		OAKS DRIVE OON, MN 5627	3		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU	ILL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION)	ON SHOULD BE	(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATI	ON)	TAG	CROSS-REFERENCED TO THE DEFICIENCY		DATE
21390	Continued From page	e 88		21390			
		is shirt, and apply a foo					
		He continued with his state gait belt and placed					
	•	4's wheelchair brakes					
		bed touching both hand					
		ned up the used supplie	es in				
	the room, then remov	/ed nis solled gloves the trash. NA-A left R2₁	4'e				
	, ,	g his hands or performing					
	any further hand hygi	ene, and assisted anot					
staff member with a transfer of a different resident.							
	_	n 10/14/15, at 8:49 a.m					
	gloves after performir	ng perineal care, and sh	nould				
		ds prior to leaving R24'					
	room to help with and was just nervous."	other resident, "I know t	nat. I				
	at 6:28 a.m. R31 was	f morning cares on 10/1 being assisted by nurs	ing				
		dressing. NA-H removad with gloved hands,	/ed				
	· ·	ad with gloved flands, ares and applied a new					
		A-H removed her soiled					
	gloves and assisted F	R31 to turn onto his side	θ,				
		lift sling underneath of	him.				
	NA-H left the room ar		0				
	mechanical lift to transfer R31 from bed to his chair. NA-H did not wash her hands after removing her gloves which were used to complete perineal cares for R31. NA-H assisted		3				
			sted				
		area in his wheelchair,					
		and cleaned up the use					
		rning cares. NA-H wasling the soiled linens in th					
	soiled utility closet.	ig the solied litteris iff th	IC				
	-	10/15/15, at 1:37 p.m.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			(X3) DATE SURVEY COMPLETED	
		00314	B. WING		10	/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	A UE NEM I UNDUI	N OAKS DRIVE NDON, MN 56273			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21390	after removing her glo	uld have washed her hands oves when caring for R31.	21390			
	2:35 p.m. registered rof disposable gloves bedpan. RN-B complher gloved hands, the from R14's buttock. Fhandwashing, or char performing perineal codressing from R14's buttosk, and the nursing reported it. RN-B renapplied new ones witt RN-B proceeded to mouttook, and prepare applied to the wound RN-B removed the glaroom to retrieve a diff was applied to R14's	ange her gloves after are prior to removing the buttock. RN-B stated the old be completely soiled with g assistants should have noved her soiled gloves, and nout washing her hands.				
	stated she did not cor including washing her gloves, but should ha	hands, after removing her ve.				
	identified staff should	y/Clean policy dated 2/2014, use clean gloves to remove and wash their hands after				
	at 8:10 a.m., nursing perineal cares for R5	morning cares on 10/14/15 assistant (NA)-C provided using gloved hands. the used wash basin and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA	l '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
THE PERSON CONNECTION		Α.	A. BUILDING:			WII LETED		
		00314	B.	B. WING			0/20/2015	
NAME OF P	ROVIDER OR SUPPLIER	STRE	EET ADDRES	S, CITY, STAT	E, ZIP CODE			
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON	GLEN OAK V LONDON	KS DRIVE I, MN 56273	3			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
21390	Without washing her pair of gloves, and platet, followed by R57 bathroom, rinsed R57 same gloved hands, I could insert them. W same gloves, NA-C g bagged up soiled clot garbage, and placed After depositing the butility area, NA-C returned to the still unwashed. In an interview on 10/stated she should wa after cares." NA-C st "changes gloves" and scrubs" to cleanse her when interviewed on licensed practical nur "training annually for stated staff actually "I handwashing." LPN-done "before and after toileting, with any bod wear gloves." When interviewed on RN-C stated hand hy washing, should be p is provided, and after When interviewed on RN-A stated hand hy after perineal care, ar removed.	m and removed her gloves. hands, NA-C donned a new aced R57's stockings on his is shoes. NA-C entered the is shoes. NA-C entered the is dentures, and, with the neld R57's dentures so R57 hile continuing to wear the ave R57 his glasses, then thing, as well as the a new liner in the trash can. agged items in the soiled transport of the image o		1390				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			X3) DATE SURVEY COMPLETED		
		00314		B. WING		10/2	20/2015
	ROVIDER OR SUPPLIER TINE LIVING COMMUNIT	Y OF NEW LONDON	100 GLEN (RESS, CITY, STA DAKS DRIVE ON, MN 5627			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21390	identified staff should completed, then wash A facility Handwashin dated 8/2014, identifical alcohol-based hand swater after direct combandling clean or soil removing gloves. Furgloves were not to be washing. SUGGESTED METH director of nursing an review the facility's pomonitoring, tracking, infections treated with	remove their gloves who and dry their hands. g / Hand Hygiene policy ed staff should use an eanitizing rub or soap an tact with residents, befored dressings, and after of their, the policy identifies used to replace hand OD OF CORRECTION: d/or their designee should on their designees should be should b	d d The	21390			
21830	-		21830				

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	a Department of Healti		A (70) MILLETON	(VO) MULTIPLE CONCERNICATION			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ` ` `	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:				
		00314	B. WING		1	0/20/2015	
NAME OF P	ROVIDER OR SUPPLIER	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
			00 GLEN OAKS DRIVE				
BENEDIC	TINE LIVING COMMUNIT	TY OF NEW LONDON	IEW LONDON, MN 562				
	OUR MAA DV OT				- CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21830	Continued From page	e 92	21830				
	(h) If a resident wh	o enters a facility is					
	unconscious or coma						
		cility shall make reasonable	ام				
	· ·	ider paragraph (c) to notif					
		er or a person designated					
	,	it as the person to contact	I				
	an emergency that th						
		y. The facility shall allow	the				
	family member to par						
	planning, unless the f	facility knows or has reaso	on				
	to believe the residen	nt has an effective advanc	e				
		ary or knows the resident	I				
		at they do not want a fam	ily				
		reatment planning. After					
		mber but prior to allowing	a				
	family member to par						
	1	must make reasonable					
	· · · · · · · · · · · · · · · · · · ·	h reasonable medical					
	practice, to determine						
		e directive relative to the decisions. For purposes	of				
		onable efforts" include:	OI				
		personal effects of the					
	resident:						
	· · · · · · · · · · · · · · · · · · ·	medical records of the					
	resident in the posses						
	_ ·	emergency contact or					
		cted under this section					
		has executed an advance	;				
	directive and whether						
	physician to whom the	e resident normally goes	for				
	care; and						
	(4) inquiring of the	physician to whom the					
	resident normally goe	es for care, if known,					
	whether the resident	has executed an advance	·				
		notifies a family member					
		cy contact or allows a fam	ily				
	member to participate	e in treatment planning in					
	accordance with this	paragraph, the facility is r	not				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00314		B. WING		10/20/2015	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 10/20	
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON	OAKS DRIVE OON, MN 5627	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
21830	the notification of the emergency contact or family member was in patient's privacy right: (c) In making reason family member or designating the person and the medical recorpossession of the facility a family member or a designation notify a family memergency contact who admission, the facility social service agency agency that the resident the facility has been under the facility social service agency or location assists a facility subdivision is not liab damages on the grouthe family member or	amages on the grounds that family member or the participation of the approper or violated the s. anable efforts to notify a signated emergency contact, pt to identify family ated emergency contact by all effects of the resident reds of the resident in the efforts. If the facility is unable abor or designated eithin 24 hours after the shall notify the county or local law enforcement ent has been admitted and anable to notify a family demergency contact. The agency and local law shall assist the facility in an a family member or rey contact. A county social all law enforcement agency in implementing this let to the resident for ands that the notification of emergency contact or the mily member was improper	21830			
	by: Based on observation review the facility faile	t is not met as evidenced i, interview and document ed to following morning or 1 of 1 residents (R24)				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00314		B. WING		10)/20/2015
	ROVIDER OR SUPPLIER TINE LIVING COMMUNIT	Y OF NEW LONDON	100 GLEN	RESS, CITY, STA DAKS DRIVE DON, MN 5627			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
21830	had intact cognition, a assistance from staff daily living. During an interview o stated he wanted to b a.m., but for approxim that had not been har it was 8:30 before the adding, "Sometimes I they are short of help A review of the Gleno nursing assistant care "Likes to get up at 5:3 During observation or was still in bed. NA-A stated he was going t should be up by now. 6:00 a.m." NA-A did in the case of the residents who eating up first and get NA-A stated staff try to can." Further, NA-A in the preference to be up eating up first and get NA-A stated staff try to can." Further, NA-A in the preference to be up eating up first and get NA-A stated staff try to can." Further, NA-A in the preference to be up eating up first and get NA-A stated staff try to can." Further, NA-A in the preference to be up eating up first and get NA-A stated staff try to can." Further, NA-A in the preference to be up eating up first and get NA-A stated staff try to can." Further, NA-A in the preference to be up eating up first and get NA-A stated staff try to can." Further, NA-A in the preference to be up eating up first and get NA-A stated staff try to can." Further, NA-A in the preference to be up eating up first and get NA-A stated staff try to can." Further, NA-A in the preference to be up eating up first and get NA-A stated staff try to can." Further, NA-A in the preference to be up eating up first and get NA-A stated staff try to can." Further, NA-A in the preference to be up eating up first and get NA-A stated staff try to can." Further, NA-A in the preference to be up eating up first and get NA-A stated staff try to can." Further, NA-A in the preference to be up eating up first and get NA-A in the preference to be up eating up first and get NA-A in the preference to be up eating up first and get NA-A in the preference to be up eating up first and get NA-A in the preference to be up eating up first and get NA-A in the preference to be up eating up first and get NA-A in the preference to be up eating up first and get NA-A in t	ated 7/22/15, indicated and required extensive to complete his activities on 10/12/15, at 6:15 p.m. be up in the morning by nately the last two montopening. R24 stated, "Tey came in to get me up hear them complain the "back Care Center-Maple e sheet, undated, included as a mentopening. R24 stated and 10/14/15, at 7:54 a.m. A entered R24's room at 10/14/15, at 8:49 a.m. I like to be up by at least 1 like to be up by at	es of I. R24 6:30 ths, Today, I. rat E 2 ded, I. R24 and ed, "I ast I. r. ass we I. 30 nose he	21830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00314		B. WING		10/2	0/2015
	ROVIDER OR SUPPLIER	Y OF NEW LONDON	100 GLEN (RESS, CITY, STA DAKS DRIVE ON, MN 5627			
(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 SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21830	During interview on 19 stated, "[R24] likes to shift won't do it. They NA-I stated R24 comptold the nurses, but not when interviewed on director of nursing (Doenough staff to get rebut the goals was to "choices." An undated facility Quetermination and Pathe facility, "Respects each resident to exercation and preferences, and conferences."	e 95 0/20/15, at 10:56 a.m. Neget up at 5:30, but night make him wait." Further plains to her and she heathing has changed. 10/16/15, at 12:02 p.m. ON) stated there is ofter sidents up in the morning to honor all resident. Juality of Life-Self puricipation policy indicate and promotes the right cise his or her own what the resident consider of his or her life." Further the properties and her with her or her own and plans of care" OD OF CORRECTION: designee could re-educt assessment of resident.	NA-I nt er, as . the n not ng, ted t of ders her, nealth : ate t	21830		NAIE	J.N.E.
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty	-one				

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