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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: F238

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00399

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245501**
2.STATE VENDOR OR MEDICAID NO.
(L2) **849623400**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY**
(L4) **1907 KLEIN STREET**
(L5) **ST PETER, MN** (L6) **56082**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **10/01/2004**

6. DATE OF SURVEY **11/21/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **79** (L18)

13.Total Certified Beds **79** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	79			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 12/09/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist
Digitally signed by mark.meath@state.mn.us
DN:cn=mark.meath@state.mn.us
Date: 2014.02.14 15:30:42 -06'00' (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/20/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN#: 24-5501

At the time of the standard survey completed August 15, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E). In addition, at the time of the standard survey complaint number H5501012 was conducted and substantiated. On October 23, 2013 a health Post Certification Revisit (PCR) was completed, but lack of verification of the life safety code deficiencies by the 70th day resulting in this Department recommending the following remedy to the CMS RO for imposition:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions, effective November 15, 2013

If the above remedy goes into effect, the facility would also be subject to a loss of NATCEP for two years beginning November 15, 2013.

On November 21, 2013, a life safety code revisit was completed and verified correction of the life safety code deficiencies and attained substantial compliance with the health deficiencies and complaint investigation, this department recommended the following action related to the imposed remedies in our letter of November 21, 2013:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions, effective November 15, 2013 be rescinded.

Since the above remedy never went into effect, the facility would not be subject to the denial of payment. Approval of the facility's temporary waiver for deficiency cited at K67 with a completion date of January 1, 2014 has not yet been verified.

Refer to the CMS 2567b for both health and life safety code.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5501

February 14, 2014

Ms. Colleen Spike, Administrator
Benedictine Living Community
1907 Klein Street
St Peter, Minnesota 56082

Dear Ms. Spike:

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 October 13, 2013 the above facility is certified for:

79 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 79 skilled nursing facility beds.

Your request for waiver of K67 has been approved based on the submitted documentation.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency or renew your request for waiver in order to continue your participation in the Medicare Program.

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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 9, 2013

Ms. Linda Nelson, Administrator
Benedictine Living Community
1907 Klein Street
St Peter, Minnesota 56082

RE: Project Number F5501201

Dear Ms. Nelson:

On November 21, 2013, we informed you that the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 15, 2013. (42 CFR 488.417 (b))

Also, we notified you in our letter of November 21, 2013, 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 November 15, 2013.

This was based on the deficiencies cited by this Department for a standard survey completed on August 15, 2013, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our November 21, 2013 notice. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On November 21, 2013, the Minnesota Department of Public Safety 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 August 15, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 13, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 15, 2013, as of October 13, 2013.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of November 21, 2013. 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 November 15, 2013, 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 November 15, 2013, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 15, 2013, is to be rescinded.

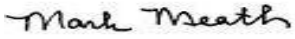
In our letter of November 21, 2013, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 15, 2013, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 13, 2013, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us
Enclosure

cc: Licensing and Certification File 5501r2_70dyallcorr.rtf

Protecting, Maintaining and Improving the Health of Minnesotans

December 2, 2013

Ms. Linda Nelson, Administrator
Benedictine Living Community
1907 Klein Street
St Peter, Minnesota 56082

RE: Project Number F5501201

Dear Ms. Nelson:

On November 21, 2013, we informed you that the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 15, 2013. (42 CFR 488.417 (b))

Also, we notified you in our letter of November 21, 2013, 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 November 15, 2013.

This was based on the deficiencies cited by this Department for a standard survey completed on August 15, 2013, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our November 21, 2013 notice. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On November 21, 2013, the Minnesota Department of Public Safety 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 August 15, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 13, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 15, 2013, as of October 13, 2013.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of November 21, 2013. 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 November 15, 2013, 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 November 15, 2013, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 15, 2013, is to be rescinded.

In our letter of November 21, 2013, 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 November 15, 2013, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 13, 2013, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Correction of the Life Safety Code deficiency cited under K67 at the time of the August 15, 2013 standard survey, has not yet been verified. Your plan of correction for this deficiency deficiency, including your request for a temporary waiver with a date of completion of January 14, 2013, has been approved

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us
Enclosure

cc: Licensing and Certification File 5501r2_70dyallcorr.rtf

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5175

November 21, 2013

Ms Linda Nelson, Administrator
Benedictine Living Community
1907 Klein Street
St Peter, Minnesota 56082

RE: Project Number S5501023

Dear Ms. Nelson:

On September 4, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 15, 2013. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On October 23, 2013, the Minnesota Department of Health completed a revisit by review of your plan of correction. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 13, 2013. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on August 15, 2013.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the August 15, 2013 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

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 November 15, 2013. (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 November 15, 2013. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 15, 2013. 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 is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 15, 2013. 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.

A copy of the Post Certification Revisit Form (CMS-2567B) from the October 23, 2013 revisit is enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 February 15, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC 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:

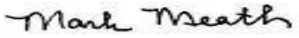
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
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P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5501r1_70dayLtr

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245501	A. Building B. Wing	10/23/2013

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE LIVING COMMUNITY	1907 KLEIN STREET ST PETER, MN 56082

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 **F0309** Reg. # **483.25** LSC	Correction Completed **09/28/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/28/2013**	ID Prefix **F0327** Reg. # **483.25(j)** LSC	Correction Completed **09/28/2013**
ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **09/13/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/MK	12/09/2013	15507	10/23/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/15/2013			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245501	A. Building B. Wing 02 - NEW BUILDING	11/21/2013

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE LIVING COMMUNITY	1907 KLEIN STREET ST PETER, MN 56082

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0069	Correction Completed **10/13/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** MM/PS	**Date:** 12/09/2013	**Signature of Surveyor:** 19251	**Date:** 11/21/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 8/13/2013		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: F238

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00399

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245501**

2.STATE VENDOR OR MEDICAID NO.
(L2) **849623400**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY**
(L4) **1907 KLEIN STREET**
(L5) **ST PETER, MN** (L6) **56082**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **10/01/2004**

6. DATE OF SURVEY **08/15/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **79** (L18)

13.Total Certified Beds **79** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	79			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Elizabeth Nelson, HFE NE II — 09/27/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Enforcement Specialist — 11/20/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 11/20/2013 CO. F238

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/20/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 245501

At the time of the standard survey completed August 15, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 0150 0001 1713 2989

September 4, 2013

Ms. Linda Nelson, Administrator
Benedictine Living Community
1907 Klein Street
St Peter, Minnesota 56082

RE: Project Number S5501023

Dear Ms. Nelson:

On August 15, 2013, 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 August 15, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5501012. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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>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 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55108-2970

Telephone: (651) 201-3794
Fax: (651) 201-3790

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 September 24, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

in your plan of correction.

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

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 November 15, 2013 (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 February 15, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: 612-201-4124 Fax: 651-215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	1907 KLEIN STREET ST PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint # H5501012 was completed. The complaint is substantiated at F327.	F 000	F00 This Plan of Correction is being submitted pursuant to the applicable Federal and State Regulations. Nothing contained herein shall be construed as an admission that the Facility violated any Federal or States Regulations or failed to follow any applicable Standard of Care.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to coordinate services between the facility and hospice agency to promote communication and provide appropriate care services for 1 of 1 resident (R26) reviewed for hospice services. Findings include:	F 309	POC accepted per fax to 9/27/13	

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

Administrator 9/16/2013

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 1 The facility did not coordinate hospice services for R26 to include a comprehensive hospice care plan which included the hospice services that were to be provided to R26. R26 was admitted 4/13, diagnoses included end stage cirrhosis, renal cell carcinoma, diabetes and depression. The physician ordered a referral to hospice on 7/18/13. On 7/24/13, a hospice nursing note to the physician stated "admit to hospice. " The significant change Minimum Data Set (MDS) dated 7/25/13, identified R26 as having severe cognitive impairment and requiring extensive assistance with bed mobility, transferring, dressing, personal hygiene, toileting and eating. The care plan dated 7/30/13, identified R26 as being admitted to hospice services however, the care plan did not include the disciplines, frequency of visits or interventions/goals hospice services was providing to R26. On 8/14/13, at 9:03 a.m. R26 was observed to be transferred with the mechanical lift from the bed to toilet, to the wheelchair. At 10:30 a.m. R26 was observed to receive total assistance with his breakfast meal. On 8/14/13, at 9:10 a.m. R26 was interviewed regarding hospice services but was unable to recall specific services provided by the hospice agency. When interviewed on 8/14/13, at 9:03 a.m. the nursing assistant (NA)-A stated a hospice aide visits weekly to provide a bath to R26. NA-A further stated the agency sends a fax weekly with the day the hospice aide will be coming.	F 309	F309 Provide Care/Services for Highest Well Being 1. On 8/15/2013 a comprehensive Hospice care plan was completed for resident #R26 including the coordination of hospice services. 2. The Hospice Program, Coordinated Plan of Care policy was reviewed and communicated to the nursing staff members at the nursing staff meeting on 9/11/2013. 3. Nursing staff members were provided with a copy of the Hospice Program Coordinated Plan of Care policy at the nursing staff meeting on 9/11/2013. 4. The DON and RN Nurse Managers will conduct Care Plan audits and audit findings, monthly to ensure inclusion of recommendations into the individualized care plan. 5. The DON and Nurse Managers are responsible for compliance. Initiated by September 28, 2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 2 When interviewed on 8/14/13, at 9:41 a.m. the registered nurse (RN)-A stated a hospice nurse visits twice a week and hospice aide visits weekly. RN-A further stated a volunteer comes in two to three times a week and pet therapy twice a month. When interviewed on 8/15/13, at 1:30 p.m. the licensed social worker (LSW)-A from hospice confirmed the hospice care plan was not in R26's chart. LSW-A called the hospice agency and requested a copy of the hospice care plan to be faxed to the facility. When interviewed on 8/15/13, at 3:17 p.m. the director of nursing (DON) confirmed a hospice care plan was not included in the record and further indicated the hospice care plan should be included the record. The DON was also not able to find any documentation of hospice aide visits in the record. Review of the faxed hospice care plan on 8/15/13, revealed the following orders, staring 7/24/13; skilled nurse visit twice every seven days, social work one time every 30 days, home health aide one time every seven days, volunteer two to three visits every seven days, clergy one time every 30 days. The Hospice Program Policy revised 2013, indicated "When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 3 resident's current status.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain safe water temperatures to minimize the risk for burns. This had the potential to affect 24 of 66 residents who were able to independently turn on the water. Findings include: On 8/13/13, at 9:16 a.m. the water premature in the bathroom sink of room 204 was felt to be hot. The water temperature was measured by maintenance director (MD)-A on 8/13/13, at 9:30 a.m. with the facility's digital thermometer and the thermometer read 131 degrees Fahrenheit (F). The water temperature in the bathroom sink of room 201 was also felt to be hot and was measured by MD-A and measured 131 degrees F. MD-A stated the facility has been struggling with maintaining a appropriate water temperature for years, and that the problem was a central hot water mixing station (he stated their goal is 125	F 323	F323 Free of Accident Hazards/Supervision/Devices 1. An estimate was approved on 9/11/2013 to replace the mixing valve unit to the water system to address water temperatures that are too hot. 2. The Tap Water policy including reporting water temperatures felt to be hot was reviewed and communicated to the nursing staff members at the nursing staff meeting held on 9/11/2013. 3. All nursing staff members were provided with a copy of the Tap Water policy at the nursing staff meeting on 9/11/2013. 4. The Plant Operations Staff Members will audit water temperatures weekly to ensure compliance. 5. The Environmental Services Director is responsible for compliance. Initiated by September 28, 2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 4 degrees F at central fill station), with long pipes running out to the long halls to the resident units, which can cause large temperature drops. He also stated that out on the units, if the tap water temperatures, in rooms are appropriate temperature then the shared bath tubs are often not getting hot water. MD-A stated the facility has made multiple efforts to troubleshoot the problem but have been unable to correct the problem permanently. He verified 118 degrees F was where tap temperatures should be. MD-A also stated there have been no incidents of resident burns, but verified there was a high risk of burns with present system. During observation on 8/14/13, at 3:00 p.m. the maintenance director (MD)-A took temperatures of water on the A unit/wing with the facility's Fieldplea digital thermometer. The A wing was the farthest distance from the centralized hot water heat system on the distribution loop and was considered the facility's locked/dementia unit. The following was noted: Room 101's water temperature in the bathroom sink was 125 degrees Fahrenheit (F) which was at the far end of the hot water supply loop distribution. Room 116's water temperature in the bathroom sink was 127 degrees F and was also located at the far end of the hot water supply distribution loop. Room 108's water temperature in the bathroom sink was 122 degrees. Room 114's water temperature in the bathroom sink was 123	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	08/15/2013

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F 323	Continued From page 5 degrees F. At that time MD-A stated the outgoing temperature averages around 138 degrees F. MD-A reported that by the time it gets down to the A and B wing the water cools by 10 degrees. MD-A reported the facility has had issues regulating the water temperatures, with most of the complaints that the temperature was too cold. MD-A verified the complaints were caused because there used to be a stop valve in hot water line that would alarm and close if the water limit was set at, "State standards." MD-A stated a few months ago had a company come out and turn off that alarm as it was preventing hot water to go through the pipes and the maintenance staff were getting called in in the middle of night, using up all of their hours and unable to work during the day to provide other maintenance services. MD-A confirmed the facility has two issues, one of comfort, keeping the temperatures hot enough on all wings. And one was safety, keeping the water temperatures cool enough in locations that were closer to the center of the hot water distribution loop. MD-A stated it was a struggle to meet both. MD-A verified contractors have been out to look at the water system to try to trouble shoot these issues but have not gotten formal estimates of what it would cost or solidified options on what should been done. The Domestic Hot Water Temperature Log form undated, identified the facility started taking weekly water temperatures on each of the wings/units on 4/10/13. Prior to that the temperatures were taken on a monthly basis. From 4/10/13 to 8/12/13, there were 76 temperatures, one temperature taken each week on each wing/unit, all recorded temperatures	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	1907 KLEIN STREET ST PETER, MN 56082

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F 323	Continued From page 6 were above the recommended 115 degrees F. Per review of facility incident reports since the last survey of 8/23/12, no burns were reported. On 8/13/13, at 2:15 p.m. the director of nursing was interviewed and stated that the facility has not had any resident burns from the water. On 8/13/13, at 2:20 p.m. the administrator was interviewed and stated the facility had ongoing issues for years with the water temperature. The administrator stated the facility had consulted with multiple contractors in the past to correct the problem. The administrator further stated there have been no incidents of resident burns the water. The facility Water Temperatures, Safety of, policy revised 4/10, identified that water heaters that service resident rooms, bathrooms common areas and tub/shower areas shall be set to temperatures of no more than 118 degrees F, or the maximum allowable temperature per state regulation. The policy instructed that maintenance staff was responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log. The policy directed that maintenance staff shall conduct periodic tap water temperatures checks and record the water temperature in a safety log. The policy identified that if at any time water temperatures feel excessive to the touch (i.e. hot enough to be painful or cause reddening of the skin after removal of the hand from the water), staff would report this finding to the immediate supervisor. It also identified that staff would be educated to turn on both hot and cold water on to reach a comfortable temperature prior to having a	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	1907 KLEIN STREET ST PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7 resident wash his/her hands, face etc... Or prior to aiding a resident with personal cares.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to provide ongoing fluid monitoring following a hospitalization for chronic obstructive pulmonary disease (COPD) exacerbation (worsening of lung disease that blocks airflow and makes breathing difficult) for 1 of 1 resident (R144) in the sample who was reviewed for hydration needs. Findings include: The facility did not monitor R144 total fluid intake to ensure the resident was meeting physician ordered fluid restriction. R144 was admitted to the facility on 1/4/13, from the hospital with diagnoses including exacerbation of COPD, adenocarcinoma of the lung (post radiation) and hypertension. The admission orders indicated a 1,000 ml (millimeter) fluid restriction. Review of the nursing notes, dietary notes and mediation administration records revealed no monitoring of R144's total intake. The initial temporary care plan dated 1/3/13, identified R144 as being independent in eating and on a 1,000 ml fluid restriction however	F 327	F327 Sufficient Fluid to Maintain Hydration 1. Monitoring of fluid intake was not completed for resident R144. 2. The intake monitoring policy Encouraging/Restricting Fluids was reviewed and communicated to the nursing staff members at the nursing staff meeting held on 9/11/2013. 3. All nursing staff members were provided a copy of the Encouraging and Restricting Fluids policy at the nursing staff meeting on 9/11/2013. 4. The RN Nurse Managers will audit the intake forms monthly to ensure compliance. 5. The DON and Nurse Managers are responsible for compliance. Initiated by September 28, 2013.	

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	245501	A. BUILDING _____ B. WING _____	08/15/2013

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F 327	Continued From page 8 there was no intervention identified for monitoring of R144's fluid intake. The temporary care plan also identified R144 as being on oxygen. On 1/8/13, the resident discharged from the facility against medical advice. When interviewed on 8/15/13, at 2:45 p.m. the director of nursing (DON) stated fluid intake monitoring for R144 was not done. The DON stated the physician order for fluid 1,000 ml fluid restriction was electronically transcribed as a general order so it was not noted on the treatment sheet which would have identified amount of fluids at meals and medication pass and prompted staff to monitor fluid intake. The policy Encouraging and Restricting Fluids undated, directed staff to record fluid intake on the treatment sheet in Matrix, Designate the amount of fluids to be given at each meal and between meals or with med passes.	F 327		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call systems in all areas were functioning properly. This had the potential to affect 3 of 35 (R55, R8, R11) residents reviewed for calls lights systems.	F 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	08/15/2013

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F 463	Continued From page 9 Findings include: On 8/12/13, at 7:01 p.m., the call light in room 216 for R8 was tested for proper functioning. The call light was observed to not activate the hall visual display or the audible alarm when tested. On 8/12/13, at 7:04 p.m. licensed practical nurse (LPN)-A, verified the nonfunctioning call light for R8 in room 216. LPN-A took the call unit from the wall bracket in the bathroom and placed in the bedside bracket, hooked air bulb to it and attempted to verify unit was working. However, when alarm was activated, the display at end of hall showed it as the bathroom call light being on, and there was now no call light in bathroom any more. On 8/14/13, at 1:37 p.m. maintenance director (MD)-A pressed R55's call light that was attached to the wall next to the bed. The call light system did not go off. MD-A stated R55 did not use her call light, but that every room needed to have a functioning call light. MD-A stated the facility had a computerized monitoring system to monitor whether call light systems batteries were going low, but staff had not complete call light audits to ensure call light systems were working properly as this would be very time consuming. MD-A added that it was hard to keep track of the call lights as staff sometimes move call lights to different locations or maintenance staff does not reprogram the call light units for the right location, so a call light reading low in room 416 could actually be a call light in room 101. During observation and interview on 8/15/13, at 10:42 a.m. R11's call light was checked. R11 stated staff just changed it yesterday, and	F 463	F463 Resident Call System – Rooms/Toilet/Bath 1. Resident call lights were audited for function and repaired as needed. 2. The Call Light policy was reviewed with nursing staff members at the nursing staff meeting held on 9/11/2013. 3. The Nursing Assistants will monitor the call lights on a monthly basis for proper location and function. 4. The Nurses and RN Nurse Managers will audit the monitoring sheets on a monthly basis. 5. All nursing staff members were provided a copy of the Call Light policy at the nursing staff meeting on 9/11/2013. 6. The DON and Nurse Mangers are responsible for policy compliance. Initiated by September 28, 2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	08/15/2013

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F 463	Continued From page 10 clarified that the staff thought the wall unit was not working and replace that component. The call light was a bulb type call light that required pressure to push the bulb and set off the call light. At that time the bulb was pushed 20 times, on the 21st push the call light went off. The call light was reset and attempted again, this time it took 15 times for the bulb to be pushed and it did not go off. Upon further observation the bulb had a tear at the base where it connected to the cord attached to the wall. The registered nurse (RN)-B entered the room and checked the call light and verified the bulb had a tear and was not working. RN-B went to get a new call light bulb. R11 stated she used the call light primarily in the evening for help to get ready for bed and if she needed assistance over night, but did not need it last night. On 8/15/13, at 3:53 p.m. the director of nursing (DON) stated the facility had a system in place for auditing the location of the call lights and that the lights were with-in reach, but did not have a system for monitoring or auditing whether call lights were functioning properly. DON was informed at this time that there were three call lights that were not functioning properly that the facility did not identify. DON stated there was a computerized system to monitor low batteries but not for broken equipment or if the equipment had not been used for a long time because then the computerized system does not update. The facility policy reviewed 8/13, identified each resident would be provided with a functioning , accessible call light or other appropriate signaling device. It identified audits were done monthly to ensure proper placement of call lights as well as proper functioning. The facility was unable to	F 463		

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	245501	A. BUILDING _____ B. WING _____	08/15/2013

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F 463	Continued From page 11 provide documentation that monthly audits were completed.	F 463		

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	245501	A. BUILDING 02 - NEW BUILDING B. WING _____	08/13/2013

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 13, 2013. At the time of this survey, Benedictine Living Community of St. Peter was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145 Facsimile: 651-215-0525, or	K 000	F00 This Plan of Correction is being submitted pursuant to the applicable Federal and State Regulations. Nothing contained herein shall be construed as an admission that the Facility violated any Federal or States Regulations or failed to follow any applicable Standard of Care. POC ok W/TW for K67 11-19-13 RECEIVED SEP 23 2013 MINNESOTA DEPARTMENT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 09.24.2013

EXIT: 08.15.2013

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

TITLE: Administrator

(X6) DATE: 9/15/2013

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**08/13/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1	K 000		

By e-mail to:
Barbara.Lundberg@state.mn.us, and
Marian.Whitney@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Benedictine Living Community of St. Peter was constructed in 2006, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction. The nursing home is separated from a hospital and a senior housing facility by 2-hour fire wall assemblies, with opening protectives consisting of labeled, self-closing, positive latching, 90-minute fire rated door assemblies.

The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility also has automatic smoke detection in all sleeping rooms. The facility has a capacity of 79 beds and had a census of 66 at time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**08/13/2013**

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K 067	Continued From page 2	K 067		
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A This STANDARD is not met as evidenced by: Based on a staff interview and documentation review, the facility's fire/smoke dampers had not been maintained in accordance with the requirements of NFPA 90A (1999 edition). This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect 79 of 79 residents, staff and visitors in the event of a fire. FINDINGS INCLUDE: On 08/13/2013 at 11:55 AM, during a review of available records, no documentation could be provided verifying the facility's fire/smoke dampers were inspected and tested within the previous four years. This deficient practice was not in conformance with the requirements at NFPA 90A (1999) Chapter 3, Section 3-4.7. This finding was confirmed with the chief building engineer.	K 067	K067 NFPA 101 Life Safety Code Standard 1. The fire/smoke dampers will be inspected. 2. The proposed completion date is by ~~October 31, 2013~~. 3. The Environmental Services Director is responsible for arranging the inspection and completing the required inspection. TW 1-31-14 per t/c w/Admin AS	
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 18.3.2.6, NFPA 96	K 069		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 069	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility had prepared foods outside of the main dietary kitchen, using food products which could create grease-laden vapors. These cooking operations were not protected by a Type-I range hood with a UL-300 automatic fire extinguishment system. In a fire emergency, this deficient practice could adversely affect 25 of 79 residents, staff and visitors within the affected smoke compartment.. FINDINGS INCLUDE: On 08/13/2013 at 1:10 PM, during a staff interview, it was confirmed that staff regularly prepared fried eggs for residents in the Eagle Wing Neighborhood Kitchen, using vegetable oil-based spray to coat the bottom of the frying pan, and this cooking operation was not protected by a Type-I range hood with a UL-300 automatic fire extinguishment system, in accordance with NFPA 96 (1998 edition) and MDH Policy. This deficient practice was confirmed with the chief building engineer.	K 069	K069 NFPA 101 Life Safety Code Standard 1. The preparation of eggs for resident utilizing a vegetable oil-based spray to coat the bottom of the frying pan in the neighborhood kitchens was discontinued on 8/13/2013. 2. The completion date is October 13, 2013. 3. The Culinary Services Director is responsible for monitoring the preparation of eggs for residents on the neighborhoods and assuring compliance.	

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Tuesday, November 19, 2013 2:29 PM
To: 'jan.suzuki@cms.hhs.gov'
Cc: 'Linda Nelsen'; Shellum, George (DPS); Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Loveland, Jim (MDH); Meath, Mark (MDH)
Subject: Benedictine Living Community of St Peter (245501) K65 Temporary Waiver Request

This is to inform you that I am accepting Benedictine Living Community of St Peter's request for a temporary waiver until 1-31-14 for K67, testing of smoke dampers. The exit date was 8-15-13.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

Name of Facility			2000 CODE
Benedictine Living Community of Saint Peter	#245501	St. Peter, MN	

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K 067 A temporary waiver is requested for NFPA 101 Life Safety Code Standard	A temporary waiver for K067 is being requested until 01-31-14. A. A temporary waiver for K067 is needed because: 1. The company who installed the Fire and Smoke Dampers were contacted to complete the required four year inspection and testing and were not able to be reached, either they are no longer in business or have changed their contact information. 2. Other vendors have been contacted to perform the inspection and testing, but are not within our local area to complete the inspection. 3. Other Administrators have been contacted to inquire of potential vendors to complete the inspection. 4. The facility continues to make contact with potential vendors to complete the inspection. 5. The requirements of an internal inspection and testing are under review with the local staff to complete the inspection internally. B. The facility was constructed in 2006, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction. The nursing home is separated from a hospital and senior housing facility by 2-hour fire wall assemblies, with opening protectives consisting of labeled, self-closing, positive latching, 90-minute fire rated door assemblies. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored by automatic fire department notification. The facility also has automatic smoke detection in all sleeping rooms. Heating, ventilation, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specification.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title Fire Safety Supervisor	Office State Fire Marshal	Date 11-19-13