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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: FKFZ

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 **09/24/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

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):

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 09/29/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/29/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245501

September 29, 2015

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

Dear Ms. Nelsen:

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 September 10, 2015 the above facility is certified for or recommended for:

79 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 29, 2015

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

RE: Project Number S5501025

Dear Ms. Nelsen:

On August 27, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 13, 2015. 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 September 24, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 14, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 13, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 10, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 13, 2015, effective September 10, 2015 and therefore remedies outlined in our letter to you dated August 27, 2015, will not be imposed.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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	9/24/2015

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 **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **09/10/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/10/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/10/2015**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **09/10/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **09/10/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/10/2015**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **09/10/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/10/2015**	ID Prefix **F0456** Reg. # **483.70(c)(2)** LSC	Correction Completed **09/10/2015**
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	KS/kfd	09/29/2015	03048	09/24/2015
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
8/13/2015			

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 A. Building B. Wing	(Y3) Date of Revisit
245501	02 - NEW BUILDING	9/14/2015

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0046	09/10/2015	ID Prefix Reg. # NFPA 101 LSC K0072	09/10/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/kfd	09/29/2015	35482	09/14/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/12/2015

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: FKFZ

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 **08/13/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **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):

17. SURVEYOR SIGNATURE Date :
Holly Kranz, HFE NE II 09/14/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/21/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 27, 2015

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

RE: Project Number S5327025

Dear Ms. Nelsen:

On August 13, 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. 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>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 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:

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Kathryn.serie@state.mn.us
Office: (507) 476-4233
Fax: (507) 537-7194

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 22, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 13, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 13, 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. Gary Schroeder
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

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 _____	08/13/2015

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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 2 residents (R67) reviewed for choices received bathing frequency according to her preferences. Findings include: R67's annual Minimum Data Set (MDS) dated 2/19/15, indicated choosing her type of bath or shower was very important to R67.	F 246	F246 Reasonable Accommodation of needs/preferences 1. Resident (R67) was interviewed for bathing preference and care plan was updated 8/12/15. 2. During care conferences residents who trigger bathing as very important will review their preferences. 3. A review of the policy regarding resident bathing will be reviewed and	9/10/15

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

Electronically Signed | 09/09/2015

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	245501	A. BUILDING _____ B. WING _____	08/13/2015

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BENEDICTINE LIVING COMMUNITY	1907 KLEIN STREET ST PETER, MN 56082

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F 246	Continued From page 1 R67's quarterly MDS dated 5/18/15, identified a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact), and identified R67 required physical help with bathing of one staff. R67's Care Area Assessment (CAA) for activities of daily living dated 3/4/15, identified R67 required assistance with all activities of daily living due to hemiplegia. Additionally, the CAA identified R67 was self-determined in regard to what tasks she wanted done and when. R67's care plan dated 5/27/15, identified a self care deficit r/t (related to) CVA (stroke) and indicated R67 required assistance with all of her activities of daily living. The care plan further identified R67 received a shower weekly. The care plan did not identify any preferences for bathing frequency. During interview on 8/10/15, at 1:07 p.m. R67 stated she would like a bath every other day, but only got a bath once a week. R67 stated she had never been asked her preferences for bathing frequency. During a follow-up interview on 8/12/15, at 12:11 p.m. R67 confirmed she would like more than one bath per week and was never offered one. R67 indicated her usual bath day was Friday. During interview on 8/12/15, at 1:31 p.m. nursing assistant (NA)-A indicated that baths were changed based on resident request and some were based on family requests for frequency. NA-A stated the bath schedule changed a lot based on admissions on the short stay wing. The bathing schedule for R67's unit (a long-term unit)	F 246	shared with nursing staff at the nursing meetings on 9/9/15. 4. Nurse managers will review at care conferences. The policy and survey results were reviewed at the quality council meeting on 8/27/15. 5. The Don and Nurse managers are responsible for compliance. Initiated by September 10, 2015.	

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F 246	Continued From page 2 had not changed for several months and had been in place prior to her taking over bath duties a couple of months ago. NA-A stated R67 was a Friday evening bath. NA-A stated she only gave the day baths and sometimes R67 would refuse baths, but was agreeable if she was approached the right way. During interview on 8/12/15, at 1:37 p.m. registered nurse (RN)-A stated the aide that gave the residents their bath should ask them about any preferences. RN-A stated R67 had a care conference last in 5/15; however, was not asked about her bathing preferences specifically. During further interview on 8/12/15, at 1:40 p.m. RN-A stated R67 had been refusing some baths back in 2013; however, had not been refusing them lately and did not have any further documentation related to bathing frequency or whether R67 wanted more baths. During interview on 8/13/15, at 11:02 a.m. the director of nursing (DON) stated residents' bathing schedules should be adjusted to accommodate preferences. The facility policy entitled Shower/Tub Bath, last revised 10/10 did not address whether resident baths would be scheduled according to preferences.	F 246		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		9/10/15

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F 282	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care related to toileting needs for 1 of 2 residents (R64) reviewed for urinary incontinence and failed to follow the plan of care related to personal grooming for 1 of 3 residents (R74) reviewed for grooming needs. In addition, the facility failed to follow the plan of care for 1 of 3 residents (R74) reviewed with non pressure related skin concerns. Findings include: Review of R64's annual Minimum Data Set (MDS) dated 2/23/15, included diagnoses of cerebral vascular disease (CVA), muscle weakness and history of falls. According to the MDS, R64 requires extensive assistance of 1 staff with toileting needs and transfers and R64's Brief Interview for Mental Status (BIMS) score was 15 indicating intact cognition. Review of R64's current plan of care identified the resident as having alteration in elimination related to cognitive and physical limitations and evidence of frequently being incontinent of bladder and occasional bowel. The plan of care indicated R64 frequently attempts to toilet self. Interventions included: (1) 1 assist with toileting every 2 hours and as needed; (2) assist with changing incontinent pads when needed; (3) assist with adjusting clothing when toileting the resident and (4) provide 1 assist with transfers with the use of a walker and safety belt. Review of the nursing assistant (NA) daily care sheets directed the staff	F 282	F282 Services by Qualified Persons/Per Care Plan 1. Resident (R64) BIMS score was 11 indicating moderate impairment. Resident has been offered toileting every two hours. Bowel and Bladder monitoring was initiated on 9/1/15. A bladder incontinence policy was not requested and is attached. Chin hairs were removed from (R764) on 8/12/15 and nails were groomed and cleaned on 8/13/15. Bruises on hand of (R74) were investigated and a reasonable conclusion was the result of a fall on 8/7/15. 2. Toileting training was provided to staff involved on 8/12/15. The Bladder Incontinence policy and training will be provided to nursing staff at the nursing meeting on 9/9/15. Grooming procedures and policy will be provided to staff members at the nursing meeting on 9/9/15. Follow up on falls will include 72 hour monitoring. 3. A review of the policies for incontinence, grooming and falls follow up will be reviewed with staff at the nursing meetings on 9/9/15. The policy and survey results were reviewed at the Quality Council meet6ing on 8/27/15. 4. Nurse Managers will audit tracking sheet for incontinence response. visual audit of grooming and record audit of fall events weekly.	

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F 282	Continued From page 4 to toilet R64 every 2 hours and wears an incontinent brief. Interview with the nurse coordinator (NC)-A on 3/12/15, at 2:00 p.m. indicated residents that exhibit incontinence are toileted every 2 hours per facility standard of practice. She also indicated R64 should be on a every 2 hour toileting program due to his risk of falls and attempting to toilet self. During observations on 8/11/15, from 9:00 a.m. to 12:00 p.m. [3 hrs] it was observed that R64 toileted himself. R64 called out for help when required staff to assist off the toilet and the surveyor subsequently alerted staff. Nursing assistant (NA)-A responded and assisted R64 off the toilet and a small amount of urine was noted on the brief. NA-A changed the brief and assisted pulling up the pants. At this time, R64 was noted be unsteady and required assistance with the transfer. When interviewed at this time (12:00 p.m.) NA-A indicated R64 will toilet himself and usually manage his own incontinence pad. R64 was observed on 8/11/15, from 12:00 p.m. to 3:30 p.m. [3 1/2 hrs]. During this observation R64 had not been toileted by staff until 3:30 p.m. R64 was observed to toilet himself and ring for assistance while sitting on the toilet. The resident was partially sitting on his pad with a large amount of urine on the incontinent pad. NA-A assisted R64 with changing the incontinent pad, pull up his pants and assist him off of the toilet. It was again noted R64 was unsteady with the transfer off the toilet. During observations of R64 on 8/12/15, from 8:30 a.m. to 11:00 a.m. [2 1/2 hrs]. R64 had not been	F 282	5. The DON and Nurse Managers are responsible for compliance. Initiated by September 10, 2015.	

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F 282	Continued From page 5	F 282		

toileted until 11:00 a.m., when the resident asked a visitor to let the staff know he needed to use the toilet. By the time staff arrived at 11:00 a.m. R64 had already transferred himself onto the toilet. Interview with NA-B indicated R64 will toilet himself at times but is unable to get off of the toilet and requires staff assistance. NA-B further indicated R64 should be on a every 2 hour toileting plan due to his unsteadiness and history of falls.

Observations on 8/12/15, from 12:00 p.m. to 3:00 p.m. [3 hrs.] noted that R64 had not been toileted until 3:00 p.m. when the resident rang for assistance. NA-B assisted R64 with the incontinent brief and transfer to wheelchair. R64 had put himself on the toilet prior to staff arrival to the room. R64 had a moderate amount of incontinent urine on his brief and had been sitting on a portion (approximately a quarter) of the urine soaked brief while seated on the toilet. Interview with NA-B at this time confirmed R64 was incontinent of urine. NA-B also indicated R64 often transfer himself onto the toilet so he is not always offered toileting although confirming R64 should be offered toileting every 2 hours.

Review of the NA toileting schedule logs for R64 confirmed the resident had not been toileted every 2 hours on 8/11/15 and 8/12/15 per the plan of care.

A policy for bladder incontinence was requested but not provided by the facility.
Review of R74's quarterly Minimum Data Set (MDS) dated 6/30/15, included diagnoses of dementia with delusional features. According to the MDS, R74 required extensive assist with hygiene and dressing and the Brief Interview for

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Mental Status (BIMS) score was 7 indicative of severe cognitive impairment.

Review of R74's current plan of care dated 7/14/15, identified the resident as having a self care deficit related to cognitive impairment evidenced by the inability to complete tasks on her own. Goals included resident will be clean and well groomed daily, assist as able, assist of one with bathing, dressing and grooming and ensure that resident is shaved daily or per their request. Review of the unit bath schedule identified R74 as having a Wednesday evening bath.

R74 was observed on 8/10/15, at 1:59 p.m. to have several long hairs on her chin and around the corners of her mouth as well as on her top lip. Resident's fingernails were also observed to be dirty, jagged and had chipped fingernail polish.

On 8/11/15, at 9:30 a.m. R74 was observed sitting in her wheelchair in the dayroom by the door. R74's fingernails remained dirty, long and jagged and facial hair was again noted. On 8/12/15, at 8:05 a.m. R74 was observed sitting in her wheelchair in the dining area. R74 was noted to continue to have dirty, long and jagged fingernails and facial hair. On 8/13/15, at 8:05 a.m. R74 was observed sitting in her wheelchair in front of her room. R74's fingernails remained dirty, long and jagged and long facial hair was noted on her chin and the sides of her mouth as well as short hairs along the chin line and on her top lip.

Interview with the nurse coordinator (NC)-A on 8/13/15, at 8:05 a.m. verified that R74 had not been shaved nor had her fingernails been

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cleaned and trimmed. She also indicated that R74 had a bath 8/12/15 on the evening shift and that her nails should have been cleaned and trimmed at that time. NC-A stated residents were to be shaved everyday. NC-A asked R74 if she could, "shave those hairs off" and R74 stated "well sure!".

The Shaving-Electric Shaver policy revised 5/10 identified that nursing staff will shave residents daily and as needed. The policy for Care of Fingernails/Toenails revised 2010, General Guidelines 1. Nail care includes daily cleaning and regular trimming.

R74 was observed on 8/10/15, at 1:59 p.m. to have a dark purple bruise on the top of her right hand, as well at on the base of the right thumb. On 8/11/15, at 9:30 a.m. R74 was observed sitting in her wheelchair in the dayroom. At this time another bruise was noted between the second and third fingers on the right hand. On 8/12/15 at 7:59 a.m. R74 was observed in dining area. Right hand bruising continues as above. She stated , "oh who knows how I did that, no one hurt me."

Review of the medical record identified that R74 had fallen on 8/7/15, and had bruising to her hip and knee. No note of the bruising to her right hand was documented. The current physician orders identified that R74 received aspirin 81 mg (milligrams) daily as well as Celebrex 200 mg daily, both of which may cause increased risk of bruising. The care plan dated 7/14/15, identified R74 as having a risk for bruising and skin tears related to fragile skin and not recognizing safety concerns. The care plan directed staff to (1) analyze resident's bruises and skin tears to

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F 282	Continued From page 8 determine if there is patterns or trends, (2) encourage removal of foot pedals on wheel chair except with transport, (3) handle resident with care during direct care, (4) leg protectors as allows, (5) measure and record description of bruises and skin tears (location, size (length and width), color, surrounding skin, presence/absence of pain and healing. Interview with the nurse coordinator (NC)-A on 8/13/15, at 8:05 a.m. verified the bruising to R74's hands had not been reported and were not being monitored. NC-A asked R74 whether anyone had hurt her and she stated, "oh no." NC-A verified the care plan was not followed regarding monitoring and reporting of bruising. She stated that staff should be monitoring the skin with cares and the bruises should have been reported. She instructed the staff nurse to measure the bruises and document them. The policy for Reporting Falls and Injuries reviewed 8/12/15, identified events to report immediately including 2. Any unexplained injury (bruises, skin tears, etc. of unknown origin). "all of the above incidents are to be entered into the events section of Matrix, an email is to be sent to the Nurse Manager informing them of the incident. Follow up documentation regarding an entered incident should be linked to the event. "Theory of Cause" should be identified in the documentation for any unexplained injury (someone has a new bruise and they take Coumadin etc....."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		9/10/15

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F 309	Continued From page 9 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 for 1 of 1 residents (R6) reviewed for hospice services and failed to ensure monitoring of bruising was conducted for 1 of 3 residents (R74) reviewed for non-pressure related skin conditions. Findings include: R6's diagnoses according to the face sheet located in the medical record and dated 8/12/15, indicated encounter for palliative care and multiple sclerosis. R6's significant change in status Minimum Data Set (MDS) dated 8/8/15, indicated R6 received hospice services and was totally dependent on staff for all cares. A Brief Interview for Mental Status (BIMS) indicated a score of 8/15 (moderate cognitive impairment). The Care Area Assessments (CAAs) were still in progress and not completed. A physician's progress note dated 7/28/15, indicated R6 had experienced progressive decline with weight loss and decreased mobility and indicated a hospice consult would be scheduled.	F 309	F309 Provide Care/Services for Highest Well Being 1. Provided a communications record for staff members to be aware of hospice schedules. Bruises on hand of (R74) were investigated and a reasonable conclusion was the result of a fall on 8/7/15. A hospice care coordination policy was not requested and is attached. 2. Staff members have been informed of communication system. Follow up on falls include 72 hour monitoring. 3. A review of the communication tool and falls follow up will be reviewed with staff at the nursing meetings on 9/9/15. The policy and survey results were shared at the Quality Council meeting on 8/27/15. 4. Nurse Manages will monitor communication system for hospice services and audit fall events weekly. 5. The DON and Nurse Managers are responsible for compliance. Initiated by September 10, 2015.	

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R6's hospice IDT (interdisciplinary team) care plan dated 8/11/15, indicated a start date of hospice services of 7/31/15. The care plan indicated a goal of developing a coordinated care plan with facility staff. The admission summary section of the hospice care plan indicated nursing visits twice weekly, aides weekly, volunteers 2-3 times weekly and social work and chaplain monthly.

R6's hospice physician orders and progress sheet dated 8/10/15, indicated one social work visit with a follow up visit scheduled for the week of 8/29/15. No other notes were noted in the chart. A hospice visit schedule form, undated, documented an admit visit on 7/31/15 (no discipline indicated) and a notation for the month of 8/15 for a SW (social work) visit this week on 8/23/15. No other schedules for visits by the hospice aide, nurse or volunteers were indicated on the form.

R6's facility care plan, dated 8/12/15 indicated R6 was on hospice, however did not identify any specific interventions hospice was providing for R6.

During observation on 8/11/15, at 10:18 a.m. R6 was lying in bed with a neck pillow behind her head. A volunteer was in the room providing pet therapy with a small lap dog, which R6 was petting.

During observation on 8/11/15, at 1:45 p.m. R6 was lying in her bed, a tray of food was in front of her that was partially eaten.

During observation on 8/12/15, at 9:36 a.m. R6

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was lying in her bed, no staff were in attendance. A set of markers was on her bedside table and a drawing which was partially colored in.

During interview on 8/11/15, at 10:29 a.m. nursing assistant (NA)-C stated hospice staff generally put a sheet up on the unit with their schedule. NA-C went to the nursing assistant charting area and was unable to locate the schedule. NA-C was unaware of what disciplines were coming nor the frequency.

During interview on 8/12/15, at 9:39 a.m. registered nurse (RN)-B stated there should be a hospice communication binder at the nursing station so staff knew when hospice was coming, but was unable to locate one at this time. RN-B was unaware of any current goals or interventions related to hospice for R6.

During a telephone interview on 8/12/15, at 12:29 p.m. the hospice nurse, RN-C, stated she would be seeing R6 later today. RN-C stated R6 should have had a visit schedule left on her chart when she was admitted on 7/31/15, so that the facility was aware who was coming from the agency.

During interview on 8/13/15, at 11:02 a.m. the director of nursing (DON) stated the facility and the hospice staff needed to communicate better with each other so that both parties were aware of which staff were coming and when.

A policy related to hospice was requested, none was provided.
R74 was observed on 8/10/15, at 1:59 p.m. to have a dark purple bruise on the top of her right hand, as well at on the base of the right thumb. On 8/11/15, at 9:30 a.m. R74 was observed

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12 sitting in her wheelchair in the dayroom. At this time another bruise was noted between the second and third fingers on the right hand. On 8/12/15 at 7:59 a.m. R74 was observed in dining area. Right hand bruising continues as above. She stated , "oh who knows how I did that, no one hurt me." Review of the medical record identified that R74 had fallen on 8/7/2015 and had bruising to her hip and knee. No note of the bruising to her right hand. The active physician orders identified that R74 received aspirin 81 mg (milligrams) daily as well as Celebrex 200 mg daily, both of which may cause increased risk of bruising. The care plan dated 7/14/15 identified R74 as having a risk for bruising and skin tears related to fragile skin and not recognizing safety concerns. The care plan directed staff to (1) analyze resident's bruises and skin tears to determine if there is patterns or trends, (2) encourage removal of foot pedals on wheel chair except with transport, (3) handle resident with care during direct care, (4) leg protectors as allows, (5) measure and record description of bruises and skin tears (location, size (length and width), color, surrounding skin, presence/absence of pain and healing. Interview with the nurse coordinator (NC)-A on 8/13/15, at 8:05 a.m. verified the bruising to R74's hands had not been reported and were not being monitored. NC-A asked R74 whether anyone had hurt her and she stated, "oh no." NC-A verified the bruising on R74's hands should have been reported and monitored. She stated that staff should be monitoring the skin with cares and the bruises should have been reported. She instructed the staff nurse to measure the bruises and document them.	F 309		

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F 309	Continued From page 13 The policy for Reporting Falls and Injuries reviewed 8/12/15, identified events to report immediately including-2. Any unexplained injury (bruises, skin tears, etc. of unknown origin). "all of the above incidents are to be entered into the events section of Matrix, an email is to be sent to the Nurse Manager informing them of the incident. Follow up documentation regarding an entered incident should be linked to the event. "Theory of Cause" should be identified in the documentation for any unexplained injury (someone has a new bruise and they take Coumadin) etc....."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, document and interview the facility failed to ensure facial hair was removed and nail care was performed for 1 of 3 residents (R74) reviewed who were dependent upon staff for assistance. Findings include: R74 was observed on 8/10/15, at 1:59 p.m. to have several long hairs on her chin and around the corners of her mouth as well as on her top lip. Resident's fingernails were also observed to be	F 312	F312 ADL Care provided for Dependent Resident 1. Chin hairs were removed from (R74) on 8/12/15 and nails were groomed and cleaned on 8/13/15. 2. Grooming procedures and policy will be provided to staff members at the nursing meeting 9/9/15. 3. Review of the survey results were reviewed at Quality Council on 8/27/15. 4. The Nurse Managers will audit grooming weekly.	9/10/15

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F 312	Continued From page 14 dirty, jagged and had chipped fingernail polish. On 8/11/15, at 9:30 a.m. R74 was observed sitting in her wheelchair in the dayroom by the door. R74's fingernails remained dirty, long and jagged and facial hair was again noted. On 8/12/15, at 8:05 a.m. R74 was observed sitting in her wheelchair in the dining area. R74 was noted to continue to have dirty, long and jagged fingernails and facial hair. On 8/13/15, at 8:05 a.m. R74 was observed sitting in her wheelchair in front of her room. R74's fingernails remained dirty, long and jagged and long facial hair was noted on her chin and the sides of her mouth as well as short hairs along the chin line and on her top lip. Review of R74's quarterly Minimum Data Set (MDS) dated 6/30/15, included diagnoses of dementia with delusional features. According to the MDS, R74 required extensive assist with hygiene and dressing and R74's Brief Interview for Mental Status (BIMS) score was 7, indicative of severe cognitive impairment. Review of R74's current plan of care dated 7/14/15, identified the resident as having a self care deficit related to cognitive impairment evidenced by the inability to complete tasks on her own. Goals included resident will be clean and well groomed daily, assist as able, assist of one with bathing, dressing and grooming and ensure that resident is shaved daily or per their request. Review of the unit bath schedule identified R74 as having a Wednesday evening bath. Interview with the nurse coordinator (NC)-A on 8/13/15, at 8:05 a.m. verified that R74 had not	F 312	5. The DON and Nurse Managers are responsible. Initiated by September 10, 2015.	

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F 312	Continued From page 15 been shaved nor had her fingernails been cleaned and trimmed. She also indicated that R74 had a bath 8/12/15 on the evening shift and that her nails should have been cleaned and trimmed at that time. NC-A stated residents are to be shaved everyday. NC-A asked R74 if she could, "shave those hairs off" and R74 stated "well sure!". The Shaving-Electric Shaver policy revised 5/10 identified that nursing staff will shave residents daily and as needed. The policy for Care of Fingernails/Toenails revised 2010, General Guidelines 1. Nail care includes daily cleaning and regular trimming	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide toileting needs for 1 of 2 residents (R64) reviewed who was incontinent of urine. Findings include:	F 315	F315 No Catheter, Prevent UTI, Restore Bladder 1. Resident (R64) BIMS score was 11 indicating moderate impairment. Resident has been offered toileting every two hours. Bowel and Bladder monitoring was	9/10/15

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F 315	Continued From page 16 Review of R64's annual Minimum Data Set (MDS) dated 2/23/15, included diagnoses of cerebral vascular disease (CVA), muscle weakness and history of falls. The MDS further indicated R64 was frequently incontinent of urine but did not include a toileting program. Documentation indicated R64 requires extensive assistance of 1 staff with toileting needs and transfers. R64's Brief Interview for Mental Status (BIMS) score was 15 indicating intact cognition. The toileting needs identified on the quarterly assessment dated 5/22/15 for R64, remained unchanged from the annual MDS (2/23/15). Review of a bladder assessment dated 2/23/15, identified R64 with stress/urge urinary incontinence and that a bladder training program had not been implemented. Review of a three day bladder log dated 2/19/15, identified that R64 had small amounts of urinary incontinence throughout the day. However, documentation was missing for several shifts and was not entirely complete. In addition, analysis of the data results was not evident and/or lacked sufficient data to develop an individualized toileting plan. During observations on 8/11/15, from 9:00 a.m. to 12:00 p.m. [3 hrs] it was observed that R64 toileted himself. R64 called out for help when required staff assistance off the toilet. The surveyor subsequently alerted staff. Nursing assistant (NA)-A responded and assisted R64 off the toilet and a small amount of urine was noted on the brief. NA-A changed the brief and assisted pulling up the pants. At this time, R64 was noted be unsteady and required assistance with the transfer. When interviewed at this time (12:00 p.m.) NA-A indicated R64 will toilet himself and	F 315	initiated on 9/1/15. A bladder incontinence policy was not requested and is attached. 2. Toileting training was provided to staff involved on 8/12/15. 3. A review of the policies for incontinence will be reviewed with staff at the nursing meetings on 9/9/15. The policy and survey results were reviewed at the Quality Council meeting on 8/27/15. 4. Nurse Managers will audit tracking sheet for incontinence response weekly. 5. The DON and Nurse Managers are responsible for compliance. Initiated by September 10, 2015.	

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F 315	Continued From page 17	F 315		

usually manage his own incontinence pad.

R64 was observed on 8/11/15, from 12:00 p.m. to 3:30 p.m. [3 1/2 hrs]. During this observation R64 had not been toileted by staff until 3:30 p.m. R64 was observed to toilet himself and ring for assistance while sitting on the toilet. The resident was partially sitting on his pad with a large amount of urine on the incontinent pad. NA-A assisted R64 with changing the incontinent pad, pulling up his pants and assisting him off the toilet. It was again noted R64 was unsteady with the transfer off the toilet.

During observations of R64 on 8/12/15, from 8:30 a.m. to 11:00 a.m. [2 1/2 hrs]. R64 had not been toileted until 11:00 a.m., when the resident asked a visitor to let the staff know he needed to use the toilet. By the time staff arrived at 11:00 a.m. R64 had already transferred himself onto the toilet. Interview with NA-B indicated R64 will toilet himself at times but is unable to get off of the toilet and requires staff assistance. NA-B further indicated R64 should be on a every 2 hour toileting plan due to his unsteadiness and history of falls.

Observations on 8/12/15, from 12:00 p.m. to 3:00 p.m. [3 hrs] noted that R64 had not been toileted until 3:00 p.m. when the resident rang for assistance. NA-B assisted R64 with the incontinent brief and transfer to wheelchair. R64 had put himself on the toilet prior to staff arrival to the room. R64 had a moderate amount of incontinent urine on his brief and had been sitting on a portion (approximately a quarter) of the urine soaked brief while seated on the toilet. Interview with NA-B at this time confirmed R64 was incontinent of urine. NA-B also indicated R64

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F 315	Continued From page 18 often transfers self onto the toilet so he is not always offered toileting although confirmed R64 should be offered toileting every 2 hours. Interview with the nurse coordinator (NC)-A on 3/12/15, at 2:00 p.m. indicated residents that exhibit incontinence are toileted every 2 hours per facility standard of practice. She also indicated R64 should be on a every 2 hour toileting program due to the risk of falls and attempting to toilet self. Review of R64's current plan of care identified the resident as having alteration in elimination related to cognitive and physical limitations and evidence of frequently being incontinent of bladder and occasional bowel. The plan of care indicated R64 frequently attempts to toilet self. Interventions included: (1) 1 assist with toileting every 2 hours and as needed; (2) assist with changing incontinent pads when needed; (3) assist with adjusting clothing when toileting the resident and (4) provide 1 assist with transfers with the use of a walker and safety belt. Review of the nursing assistant (NA) daily care sheets directed the staff to toilet R64 every 2 hours and wears an incontinent brief. Review of the NA toileting schedule logs for R64 confirmed the resident had not been toileted every 2 hours on 8/11/15 and 8/12/15 per plan of care. A policy for bladder incontinence was requested but not provided by the facility.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		9/10/15

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F 323	Continued From page 19 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 ensure a comprehensive fall assessment was conducted so that interventions were identified to prevent and/or minimize the risk of fall and/or injury for 1 of 3 residents (74) reviewed with a history of falls. Findings include: R74 was admitted on 1/2/14, and the Diagnosis Report located in the medical record indicated R74 had diagnoses including: senile dementia with delusions, psychophysical visual disturbance, chronic pain, history of right hip fracture, abnormality of gait and muscular atrophy disuse. Review of R74's quarterly Minimum Data Set (MDS) dated 6/30/15, identified R74 as requiring extensive assistance of one staff for bed mobility, walking and transfers. R74 was identified with a Brief Interview of Mental Status (BIMS) assessment of 7/10, indicative of severe cognitive impairment. The MDS further identified R74 as having falls since the prior MDS assessment and identified 1 fall resulting in no injury and 2 or more falls resulting in injury (except major) - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall related injury	F 323	F323 Free of Accident Hazards/Supervision/Devices 1. Bruises on hand of (R74) were investigated and a reasonable conclusion was the result of a fall on 8/7/15. 2. Follow up on falls will include 72 hour monitoring. 3. A review of the policy on falls will be reviewed with staff at the nursing meetings on 9/9/15. The policy and survey results were reviewed at the Quality Council meeting 8/27/15. 4. Nurse Managers will audit the falls events weekly. 5. The DON and Nurse Managers are responsible for compliance. Initiated by September 10, 2015.	

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that causes the resident to complain of pain.

Review of the annual MDS Care Area Assessment (CAA) for falls dated 1/14/15, identified R74 at risk for falls because of a history of falls with a hip fracture and difficulty maintaining balance during transitions. Further items contributing to the fall risk included dementia with hallucinations (which do occasionally cause her distress) and limited safety awareness, inability to maintain standing balance related to femur fracture. Other triggers documented included use of psychoactive medications and impaired balance.
During observations on 8/11/15, at 3:00 p.m.. R74 was observed seated in her wheel chair and attempted to stand twice from the wheel chair while unattended by any staff . R74 was noted throughout the survey to propel herself in the wheelchair, wandering about the living area. It was noted that R74 did not attend any scheduled activity program and was transferred with the assist of one or two staff, depending upon her level of alertness.

During record review it was noted that R74 experienced falls on 7/31/14, 8/20/14, 5/28/15, 6/12,15, 6/15/15, 7/10/15 and 8/7/15. Documentation related to each fall was as noted: (1) Fall on 7/31/14, (2) Fall on 8/20/14, (3) Fall on 5/28/15, at 1:15 a.m. Resident was found laying on the floor at 1:15 a.m.. Resident stated she did not hit head and she just layed down because she got tired of sitting. Resident had a skin tear to left elbow measuring 2 cm which had a scant amount of blood. Skin tear was cleansed and bandaged. Resident denied pain and no other injuries were noted. The resident was assisted off the floor and into bed. The resident

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stated she didn't need to go to the bathroom and stated she slipped out of her wheelchair and the floor was slippery. Shoes were off, was attempting self transfers. (4) Fall on 6/12/15, (5) Fall on 6/15/15, (6) Fall on 7/10/15 and (7) Fall on 8/7/15.

No further documentation in the medical record was found nor provided by staff related to the above documented falls. Documentation was lacking to indicate a comprehensive fall assessment had been conducted at the time of each incident related to the fall and therefore no interventions were identified to prevent and/or to minimize the risk of further falls and/or injury. Interventions were not evaluated to determine their effectiveness and/or the need for revision (alarms).

Review the current care plan dated 7/14/15, identified R74 as having an alteration in mobility related to a previous hip fracture secondary to a fall, arthritic pain, atrophy secondary to muscular disuse which is evidenced by needing assistance with mobility, at high risk of falls. R74 was also identified as frequently self transferring or standing in front of closet door in room. Approaches included: (1) assist of 1 to transfer with FWW (front wheeled walker) and TB (transfer belt). (2) Ambulate in room and 80-100 feet with FWW and CGA (contact guard assist) with minimal assist of 1. (3) Assist of 1 with bed mobility. (4) IF propelled in wheel chair by staff/volunteer, foot rests are to be on at all times. (4) Physical therapy (PT) as ordered - will follow recommendations. (5) Auto locks placed on wheel chair due to not remembering to lock wheel chair brakes and self transfers. (6) Grippy socks at night. (7) Therapy has evaluated safety with

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F 323	Continued From page 22 use of lift chair and resident is OK to use lift chair in room.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the correct concentration level of chemical solution was maintained and monitored during the manual washing and rinsing of dishware in the three-compartment sink. This had the potential to affect all 76 residents who reside in the facility and were routinely served meals from dishware sanitized in the three-compartment sink. Findings include: During the kitchen tour on 8/11/15, at 12:00 p.m. a three-compartment sink with chemical rinse sanitization was noted. Review of the chemical monitoring logs at this time included strip testing once weekly for the past year. Chemical strip testing results averaged 300 parts-per million (ppm).	F 371	F371 Food Procure, Store/Prepare/Serve 1. The cook was trained to use the chemical strip test on 8/13/15. The Culinary Services Director updated the policy and initiated the chemical strip testing on 8/13/15. 2. The updated policy and procedure was presented to all Culinary staff and implemented on 8/13/15. 3. The policy and survey results were reviewed at the Quality Council meeting on 8/27/15. 4. The Culinary Services Director will audit the testing strip documentation compliance weekly. 5. The Culinary Services Director is responsible for compliance. Initiated by September 10, 2015.	9/10/15

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F 371	Continued From page 23 During observation on 8/13/15, at 9:15 a.m. cook-A was observed using the three-compartment sink which included a chemical sanitization rinse. Cook-A did not utilize a chemical strip test to check the concentration level of the solution to ensure proper sanitization. Interview with cook-A at this time indicated she was unaware of any chemical testing required for rinsing dishware in the three-compartment sink during dishwashing. Interview with the culinary service director (CSD) on 8/15/15, at 10:00 a.m. indicated chemical strip testing for the rinse cycle for the three-compartment sink is only done weekly. CSD indicated staff do not utilize the chemical strip testing to measure the concentration of the solution and that she is the only one who conducts the chemical strip testing. Review of the facility's procedure located above the three-compartment sink instructed staff to use a chemical test strip for testing the solution with each rinse cycle. Review of the facility policy and manufactures recommendations for Ecolab sanitizers indicates sanitizers must be tested at a minimum of once daily. Sanitizer must be within 150-400 ppm.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		9/10/15

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F 441	Continued From page 24 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper handwashing techniques were followed during personal cares for 1 of 3 residents (R55) observed during cares.	F 441	F441 Infection Control, Prevent Spread, Linens 1. Employee involved was retrained on proper technique on 8/12/15. 2. Proper hand washing technique and the policy will be shared with the nursing	

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	245501	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 25 Findings include: R55's quarterly Minimum Data Set (MDS) dated 7/13/15, identified she required extensive assistance of one staff for grooming and toileting activities, and had a Brief Interview for Mental Status (BIMS) score of 5/15 (severe cognitive impairment). During observation on 8/12/15, at 9:16 a.m. nursing assistant (NA)-B was observed performing morning cares with R55. R55 was seated on the toilet after being dressed. NA-B told R55 to stand up off the toilet so that she could perform peri-care. NA-B applied gloves and proceeded to cleanse R55's peri-area with a washcloth. When she finished, NA-B placed the soiled washcloth into a plastic bag and without washing her hands or removing her gloves adjusted R55's incontinent pad, pants and her shirt. NA-B then removed her gloves, assisted R55 into her wheelchair and without washing her hands obtained R55's toothbrush, applied toothpaste and began assisting R55 with oral care. When R55 was finished with oral cares, NA-B put away the oral care supplies, proceeded to shave the resident, brushed R55's hair then washed her hands after cares were finished. During interview on 8/12/15, at 9:29 a.m. NA-B confirmed she did not wash her hands after she completed the peri-care on R55 and then proceeded to assist R55 with oral cares. During interview on 8/13/15, at 11:02 a.m. the director of nursing (DON) stated staff should be washing their hands anytime gloves were removed.	F 441	staff at the nursing meetings on 9/9/15. The policy and survey results were reviewed at the Quality Council meeting on 8/27/15. 3. The Staff Development Coordinator will audit infection control techniques and proper hand washing weekly through November and monthly there after. The policy and survey results were reviewed at the Quality Council meeting on 8/27/15. 4. The DON and Nurse Managers are responsible for compliance. Initiated by September 10, 2015.	

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F 441	Continued From page 26 The facility policy, entitled Handwashing/Hand Hygiene, last revised 8/12, indicated staff were to wash their hands after removing gloves or aprons as well as before and after assisting a resident with toileting.	F 441		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 4 nursing units was free of odors and failed to ensure resident equipment was maintained in a clean and sanitary manner. This had the potential to affect all 20 residents residing on the Butterfly unit, families and visitors. In addition, the facility failed to ensure 2 of 2 residents (R55 & R74) with cracked wheelchair armrests had equipment maintained in functional working order and failed to ensure wall coverings were maintained in proper repair in 2 of 2 resident rooms (214 & 216) with damaged sheet rock. Findings include: During observation on 8/10/15, at 1:33 p.m. room 216 was noted to have large gouges in the sheet rock behind a recliner chair. During observation on 8/11/15, at 12:30 p.m. the Butterfly wing lobby was noted to be odorous of urine, the source was noted to be the chairs in	F 456	F456 Essential equipment, safe operating condition 1. Sheet rock repaired in rooms 214 and 216 on 8/17/15. Identified chairs were cleaned on 8/14/15. Wheelchairs were repaired on 8/19/15 with new arm rests. 2. Housekeeping and plant operations staff will be trained on policy and proper maintenance of furnishings on 9/1/15. Policy is updated to indicate housekeeping staff auditing rooms weekly for neccessary repairs of surfaces and furnishings. 3. Env services Director will monitor audits on a monthly basis. Policy and survey results were rreviewed at the quality council meeting on 8/27/15. 4. Env Services Director is responsible for compliance. Initiated by 9/10/15.	9/10/15

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F 456	Continued From page 27 the lobby area. During observation on 8/12/15, at 1:26 p.m. the Butterfly lobby continued to have a urine odor present. The recliner and arm chairs in the lobby were noted to be odorous of urine, with a whitish crusty substance noted on the red recliner next to the television. The stain was located on the inside of the armrest. Room 214 was observed at this time, with large gouged areas inside the doorway on the right and left side in the sheet rock which were approximately 10 inches in length. During observation on 8/12/15, at 1:29 p.m. the wheelchair arms on R55's wheelchair were noted to be torn and cracked, with the left armrest showing exposed foam. During observation and tour of the Butterfly unit on 8/13/15, at 8:11 a.m. the maintenance director (M)-A verified the following concerns: - M-A observed R55's wheelchair armrests and stated they needed to be replaced due to cracks in them and exposed foam. -R74's wheelchair armrests were observed with M-A at this time. Both armrests were cracking. M-A stated they should be replaced before the foam became exposed. - The wall in room 216 was observed to have large gouges in the sheet rock behind the recliner chair. The gouges were numerous and comprised an approximate area of 1.5 square feet. M-A stated the wall needed to be repaired but "What can I do, the recliner gets moved back and it gets gouged again. When the resident discharges [from the room] then I can get in to make the repairs." M-A stated he had not recently attempted to fix the sheet rock in R58's	F 456		

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F 456	Continued From page 28	F 456		

room.
-Room 214 was observed to have gouges inside the doorway in the sheet rock on both sides, and M-A indicated he would make the repairs "When the resident discharges."
-M-A confirmed the urine odor in the Butterfly lobby and stated it was "The nature of the beast, the urine odor on this wing." M-A stated the chairs were not on any kind of a cleaning schedule at this time, he relied on nursing staff to tell maintenance when steam cleaning of the upholstery should be completed. M-A verified the soiled chairs in the lobby. M-A indicated nursing staff should fill out a maintenance request slip for broken or soiled items, as he had many areas to look at in the facility.

The facility policy related to maintenance requisition slips, untitled and last revised 5/15, indicated staff would fill out a slip in the event that something needs to be inspected/fixed by maintenance staff.

The facility policy related to cleaning of common areas, untitled and last revised 3/15, indicated chairs or flooring that is soiled will be cleaned on an as needed basis - staff will fill out a requisition form for maintenance/housekeeping staff for these items.

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	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	8/12/2015 ~~08/11/2015~~

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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 12, 2015. 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	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/04/2015

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.

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@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 at two different times. The original building is a one story building with no basement of Type V(111) construction. The addition constructed in 2006, with a link to the hospital is a one story building with no basement of Type V(111) construction. The building is fully fire sprinkler protected. 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.	K 000		

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K 000	Continued From page 2 Because the original building and the addition meet the construction type allowed for new buildings, the 2 buildings will be surveyed as one building. The facility has a capacity of 79 beds and had a census of 78 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1 This STANDARD is not met as evidenced by: Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.3 and 18.2.9.1 Based on review of reports, records and interview,, it was determined that the facility failed to test emergency ligts in accordance with NFPA 101 LSC (00) Section 18.2.9.1. This deficient practice could affect how staff operate the emergency generator in the event of an emergency. Findings include: On facility tour between 9:30 AM and 11:30 AM on 08/12/2015, based on review of available documentation and inspection it was reveled that the wall mounted emergency lights in the generator room have not received a monthly test of at least 30 seconds and an annual test of at least 90 minutes.	K 046	1. Environmental Services staff members will test wall mounted emergency lights in the generator room at least 30 seconds every month and for at least 90 minutes one time per year. 2. Environmental Services Director will maintain documentation of testing. 3. Environmental Services Director is responsible for compliance. Initiated by September 10, 2015.	9/10/15
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free	K 072		9/10/15

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K 072	Continued From page 3 of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Findings include: On facility tour between 9:30 AM and 11:30 AM on 08/12/2015, it was obbserved that the front exit in the chapel was impeded by stacks of chairs. This deficient practice was observed by the Environmental Services Director (BF) at the time of discovery.	K 072	1. The items at the front exit in the chapel were removed on 8/12/15. 2. Staff members have been informed of the need to maintain clear exits throughout the facility. All staff will be informed and review the need for clear access and egress at staff meetings on 9/9/15. 3. A review of the procedure and survey results were reviewed at the Quality Council meeting on 8/27/15. 4. The Environmental Services Director is responsible for compliance. Initiated by September 10, 2015.	