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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: FQK9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00774

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245350**

2.STATE VENDOR OR MEDICAID NO.
(L2) **885740700**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST BENEDICTS SENIOR COMMUNITY**
(L4) **1810 MINNESOTA BOULEVARD SOUTHEAST**
(L5) **SAINT CLOUD, MN** (L6) **56304**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/03/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **197** (L18)

13.Total Certified Beds **197** (L17)

10.THE FACILITY IS CERTIFIED AS:

X 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

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
	195	2		
(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 :
Michelle Thompson, HFE NE II 09/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 09/17/2014 (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
09/15/1986
(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 10/27/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/29/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245350

September 17, 2014

Ms. Christine Bakke, Administrator
St Benedicts Senior Community
1810 Minnesota Boulevard Southeast
Saint Cloud, Minnesota 56304

Dear Ms. Bakke:

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 August 22, 2014 the above facility is certified for or recommended for:

2 Skilled Nursing Facility Beds

195 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 197 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 15, 2014

Ms. Christine Bakke, Administrator
St. Benedict's Senior Community
1810 Minnesota Boulevard Southeast
Saint Cloud, Minnesota 56304

RE: Project Number S5350024

Dear Ms. Bakke:

On August 1, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 17, 2014 . This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On September 3, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 17, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 22, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 17, 2014, effective August 22, 2014 and therefore remedies outlined in our letter to you dated August 1, 2014, 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,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245350	A. Building B. Wing	9/3/2014

Name of Facility	Street Address, City, State, Zip Code
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

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 **F0311** Reg. # **483.25(a)(2)** LSC	**08/22/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	**08/22/2014**	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	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	BF/KJ	09/15/2014	28598	09/03/2014
Reviewed By CMS RO				

Followup to Survey Completed on: 7/17/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 15, 2014

Ms. Christine Bakke, Administrator
St Benedicts Senior Community
1810 Minnesota Boulevard Southeast
Saint Cloud, Minnesota 56304

Re: Reinspection Results - Project Number S5350024

Dear Ms. Bakke:

On September 3, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 17, 2014. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

AH Form Approved

9/15/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00774	A. Building B. Wing	9/3/2014

Name of Facility	Street Address, City, State, Zip Code
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	**08/22/2014**	ID Prefix **20915** Reg. # **MN Rule 4658.0525 Subp. 6 A** LSC	**08/22/2014**	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 State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/KJ	09/15/2014	28598	09/03/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/17/2014

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: FQK9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00774

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245350**

2.STATE VENDOR OR MEDICAID NO.
(L2) **885740700**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST BENEDICTS SENIOR COMMUNITY**
(L4) **1810 MINNESOTA BOULEVARD SOUTHEAST**
(L5) **SAINT CLOUD, MN** (L6) **56304**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/17/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY ~~03~~ (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **197** (L18)

13.Total Certified Beds **197** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
X 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: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	195	2		
(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 :
Bruce Melchert, HFE NE II 08/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 08/29/2014 (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
09/15/1986
(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 1, 2014

Ms. Christine Bakke, Administrator
St Benedict's Senior Community
1810 Minnesota Boulevard Southeast
Saint Cloud, Minnesota 56304

RE: Project Number S5350024

Dear Ms. Bakke:

On July 17, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the 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;

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 26, 2014, 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 October 17, 2014 (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 January 17, 2015 (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 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
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
	245350	A. BUILDING _____ B. WING _____	07/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	**1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304**

(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 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide the exercise program for 1 of 1 residents (R238) reviewed for a restorative nursing program. Findings include: R238's Minimum Data Set (MDS) dated 6/25/14, included diagnosis of Alzheimer's disease, with severe cognitive impairment, required extensive assist of two for ambulation, transfers, and was not steady during ambulation. R238's careplan dated on 4/22/14 identifies,	F 311	This plan and response to these survey findings is written solely to maintain certificiation in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any requirement nor any agreement with any findings. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. 1. R-238 will have therapy reassess her potential for a nursing rehab program related to her current abilities. Nursing	8/22/14

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

Electronically Signed | 08/05/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING _____ B. WING _____	07/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

(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 311	Continued From page 1 "Potential for injury related to impaired mobility... impaired cognition secondary to dementia, ... [R238] is to ambulate in corridor with hand hold assist of one has 2ww [two wheeled walker] but difficulty in understanding how to use. The physical therapy discharge summary note 10/23/13, indicated R238 had been discharged from physical therapy due to mixed gains with poor carryover of learning. She was discharged to long-term care with restorative nursing program in place for "seated exercises". During an interview 7/16/14, at 1:10 p.m. LPN-A was asked about the restorative program for R238. She was unsure if another unit helped with that piece but knew R238 liked to walk and it helped decrease her anxiety. There was no documentation that a restorative program had been developed for R238, even though the physical therapy discharge summary identified a specific "seated exercise" program to be implemented. During an interview on 7/17/14, at 9:15a.m. LPN-B whom administers the restorative program for the facility, was unable to locate R238 in her program file and reported she has never been on a nursing restorative program. She explained the protocol for a recommendation/referral by physical therapy is for an email to be sent to the unit manager and restorative nurse. During an interview on 7/17/14, at 9:30 a.m. with an occupational therapy assistant, stated they e-mailed the unit manager and rehab nurse with restorative nursing program recommendations. She believes all recommendations/ referrals from therapies would be followed and if the nursing	F 311	will review the therapy recommendation with therapy for implementation and/or alternative approaches. 2. Nursing Managers, MDS Nurses and Rehab staff will be provided instruction on the communication process regarding nursing rehab recommendations and/or alternative approaches. Nursing and therapy have set-up a wekkly meeting to review therapy recommendations for nursing rehab. 3. Nursing Managers and/or their designee will audit therapy recommendations on those residents discharged from therapy with nursing rehab recommendations. 4. The Director of Nursing and/or designee will present to the Quality Assurance Committee at their next meeting the nursing rehab therapy recommendation audit results.	

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F 311	Continued From page 2 staff had questions a therapist would be contacted for a clarification. During an interview with RN-D and RN-C on 7/17/14, at 10:18 a.m, RN-D stated they receive therapy recommendations for restorative nursing program by e-mail. However, RN-D stated ,"These are only recommendations from therapy." RN-C confirmed that the seated exercise program was not being completed for R238. During an interview on 7/17/14, at 11:18 a.m. director of nursing (DON) stated he was familiar with R238 and the IDT(interdisciplinary team) meets weekly which includes therapy recommendations/referrals for restorative programs. The DON stated recommendations by therapy were viewed only as recommendations and not orders, but he will look at the therapy recommendations and talk with nursing. Although the discharge plan for physical therapy recommended a restorative nursing program to provide a lower extremity exercise program, the facility did not provide this service for R238.	F 311		
F 323 SS=D	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	F 323		8/22/14

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F 323	Continued From page 3 by: Based on observation, interview and document review, the facility failed to re-assess and ensure appropriate interventions were implemented for 2 of 3 residents (R151 and R238) identified as at risk for falls. Findings include: R151's diagnoses, from the admission record dated 7/17/2014, included atrial fibrillation, anemia, malaise and fatigue. The significant change Minimum Data Set (MDS) dated 4/28/2014, identified R151 had intact cognition. The MDS also indicated R151 required limited assistance of staff for transferring, walking and toileting, and that R151's balance during transition as "not steady," but able to stabilize without human assistance. The Care Area Assessment (CAA) for ADL (activities of daily living) function, dated 4/28/2014, indicated that R151's changing cognitive status and mood decline were possible underlying problems that may affect function. The CAA summary indicated R151 was recently hospitalized due to metastasized cancer, needed limited assistance with most ADLs, was alert, oriented and able to make needs known, and that a decline was expected. A bowel and bladder assessment, dated 6/2/2014, indicated R151 was able to maintain continence for more than 2 hours, and did not display any elimination patterns. The assessment summary indicated R151 was able to communicate needs, needed a limited assist of 1 with transfers and toileting, and "will continue to assist with toileting prn" [as needed].	F 323	This plan and response to these survey findings is written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any requirement nor any agreement with any findings. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. 1. The recliner with smooth surface/leather was removed from R-238 nursing unit. R-238 will have a new fall assessment completed. R-238 will be referred to therapy to re-assess transferring and walking related to her current condition. R-151 will have a new fall and bowel & bladder assessment completed. R-151 was given a pendant call light. R-151 will be referred to therapy to re-assess her transferring and walking abilitiies related to her current condition. Both residents' plans of care will be updated based on the outcomes of their individual assessments. 2. Nurse Managers and MDS Nurses will be provided education on post-fall assessments and investigations looking for patterns and mitigating factors related to individual resident falls. Residents with mutliple falls and identified with patterned activities related to their fall will be additionally reviewed at the nursing leadership meeting. 3. Nurse Managers and/or their designee	

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F 323	Continued From page 4 R151's care plan (CP), reviewed 5/14/2014, addressed R151's potential for injury, and listed interventions to remain free from falls, which included: to encourage [R151] to wear appropriate footwear/shoes; to keep the call light within reach and encourage resident to utilize it; and to assist with toileting as requested. During observation on 7/14/2014 at 6:17 p.m., R151 was in her room, lying in her bed, wearing gripper socks, and had oxygen via nasal cannula. Next to the bed was an oxygen concentrator, a walker and a wheel chair. Review of nursing progress notes from 5/1/2014 to 7/16/2014 indicated R151 had a recent history of three falls in the facility: A nursing note dated 5/11/2014 at 7:05 p.m., indicated R151 had a fall while out of the facility. The resident reported, "When I was at Fleet Farm the other day, I thought I was on level ground, but there was another step and fell on my bottom under the car." The fall occurred in the presence of R151's friend, and no additional information was available. A nursing note dated 5/23/2014 at 10:24 a.m. indicated R151 was found sitting on her bottom in her room, next to her bed at 8:15 a.m. [R151] stated she was getting up to brush her teeth when she slipped; she was barefoot, and gripper socks were put on. The interdisciplinary team (IDT) review of the fall provided no new, or additional recommendations. A nursing note dated 5/27/2014 at 11:53 p.m., indicated R151 was found sitting on her bathroom floor, with back against toilet; no injuries were	F 323	will audit resident post-fall assessments and investigations looking for patterns and mitigating factors related to individual resident falls. 4. The Director of Nursing and/or designee will present to the Quality Assurance Committee at their next meeting the resident post-fall audit results.	

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	245350	A. BUILDING _____ B. WING _____	07/17/2014

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F 323	Continued From page 5	F 323		

noted. R151 was returned to bed, gripper socks applied, and given instructions to use the call light when needing assistance. There was no indication if R151's call light had been activated. The IDT review of the fall provided no additional information.

A nursing note dated 6/27/2014 at 2:00 a.m., indicated staff responded to a call light, and found R151 "lying on her back," in front of the bathroom, with the wheelchair inside the bathroom, with its wheels unlocked. R151 reported she hit her head. The IDT review did not indicate changes to R151's plan of care.

During an interview on 7/16/2014 at 10:56 a.m., nursing assistant (NA)-A said R151 was only able to stand briefly when being assisted, but that she could be left alone to toilet. NA-A stated R151 did not always use her call light, "It depended on the day." NA-A said, when going in to check on R151 after her call light was activated, often found [R151] ambulating to, or already in the bathroom. NA-A said R151 was not on a routine toileting schedule.

In an interview on 7/17/2014, at 8:51 a.m., R151 said she has routinely gone up to the bathroom on her own, because "When I have to go, I can't wait." R151 said she used her walker, but "I can only stand for a short time, then I'll go down, I get weak in the knees."

During an interview on 7/17/2014 at 9:15 a.m., registered nurse (RN)-B acknowledged R151 does "not always use the call light," when she needs to toilet, and was, at times, "impatient." RN-B said R151 could not stand upright for long periods of time, and noted R151 was getting

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F 323	Continued From page 6	F 323		

weaker due to metastatic cancer. RN-A said the wheel chair and walker were parked "away from the bed," as a reminder for R151 to use her call light.

Although R151 had three falls in the evening while attempting to use the bathroom, there was no indication the facility had made a reassessment of R151's bladder function to determine if the current bladder program was effective. The facility did not look at R151's environment to determine if a commode could be placed next to R151's bed to assist her to be as independent as possible, and/or do frequent checks during bed time hours when the falls have occurred.

During an interview on 7/16/2014, at 2:30 p.m., RN-A stated R151 was not a "frequent faller", but did have a history of "self transfers", which likely contributed to falls. RN-A acknowledged R151's recent falls occurred when R151 was toileting. RN-A said R151 still had a "bit of independence" and this how [R151] was "expressing that desire." RN-A said the "risks and benefits" of doing the self transfers was discussed with R151 and her family. RN-A said R151's interventions to wear the "gripper socks or footwear" and "frequent" reminders to use the call light and request help to toilet. RN-A said more recent assessments, of R151's urgency and inability to tolerate walking to the bathroom, were not made. RN-A stated medications were not changed, and "no other interventions" were put in place after R151's fall on 6/27/2014.

In a subsequent interview on 7/17/2014 at 9:12 a.m., RN-A stated that R151 needed an "updated" assessment, and should have "more of

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	245350	A. BUILDING _____ B. WING _____	07/17/2014

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F 323	Continued From page 7	F 323		

a program." RN-A said R151 "might benefit from a bowel and bladder program, and more frequent checking." RN-A said "That would be a good thing to change," to help prevent future falls for [R151].

Although R151 had a pattern of falls while using the bathroom at night, there was no indication the facility reassessed her falls to determine alternative interventions to help decrease or prevent additional falls.

A review of the facility policy, Fall Management, revised 10/13, indicated the staff would "...identify and implement relevant interventions as applicable to try to minimize serious consequences of falling.

R238's diagnoses, from the quarterly Minimum Data Set (MDS)dated 3/28/2014, included anxiety disorder and Alzheimer's Disease. The MDS further indicated R238 required extensive assistance of two for ambulation and transfers, was not steady during ambulation, and had two falls since the previous MDS dated 12/30/2013.

During observation on 7/16/2014 at 6:55 a.m. R 238 walked arm in arm with LPN-A and NA-A without a transfer belt to dining room for breakfast a distance of approximately 60 feet from her room. No loss of balance was observed.

A fall incident report dated 4/20/2014 at 8:15 p.m., indicated R238 was found sitting in front of her recliner. The interdisciplinary team (IDT) concluded there were no patterns to falls noted, that R238 was impulsive, and had a history of self transfers and poor safety awareness. The IDT

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F 323	Continued From page 8 indicated a new activity intervention would be tried: "Resting in recliner." A fall incident report dated 6/19/2014 at 7:36 p.m., indicated R238 has slid herself down from recliner onto the floor. The IDT indicated no [fall] pattern noted, and no new interventions were put in place. A fall incident report dated 6/20/2014 at 4:30 p.m., indicated R238 was found kneeling next to her recliner. The IDT indicated no [fall] pattern was noted, and no new interventions were placed, even though this was the third fall from the recliner during the late afternoon and evening hours. R238's care plan dated on 4/22/14, identified, " Potential for injury related to impaired mobility, incontinence of bowel and bladder, impaired cognition secondary to dementia, ... Resident is impulsive doesn't consistently ask for help or use call light, poor safety awareness, self transfers injury impaired mobility ." Interventions included: Concave mattress in place, encourage resident to wear appropriate footwear and shoes, reposition per tissue tolerance and PRN (as needed) toileting per elimination plan of care. Ambulate in corridor with hand hold assist of one (has wheeled walker but difficulty in understanding how to use). Risks and consequences of self transfers with [family member-A] discussed on 9/24/13 which include: falls , minor injuries, fractures, head injuries and up to including death." During Interview on 7/16/14, at 9:30 a.m., RN-D reported that R238 uses many of the recliners in the common area, one has leather surface and	F 323		

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	245350	A. BUILDING _____ B. WING _____	07/17/2014

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F 323	Continued From page 9	F 323		

others are cloth. RN-D did not know if surfaces of recliners had bearing on falls, as this had not been assessed. R238 had not been assessed at time of fall as to what she was trying to do when fall had occurred.

During interview 7/16/14, at 10:30 a.m., NA-B stated, R238 attempts to transfer from the chair when she is anxious, "She just likes to move around."

During interview on 7/17/14, at 8:20 a.m. NA-B stated one of the nurses's told her not to place R238 in leather recliner due to recent falls. NA-B uses a care sheet but this information was not included.

During interview on 7/17/14, at 10:18 a.m. , RN-D and RN- C both stated they had not assessed if R238 had slipped out of the recliner, had fallen out of the recliners, or was she was trying to self-transfer for an unmet need. The recliners are used by all residents therefore they had not considered placing a non-skid surface on any of them. RN- C and RN-D both stated there no pattern noted for R238's falls even though all three falls had occurred from the recliner in the evening hours.

During interview on 7/17/14, at 11:18 a.m. the director of nursing (DON) stated he did not know if the recliner was a factor in R238's falls as this had not been assessed.

Although R238 suffered three falls while seated in a recliner in the evening, the facility did not assess this pattern of falls to determine a reason why she was falling out of the recliner or place interventions to help decease R238 risk of

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	245350	A. BUILDING _____ B. WING _____	07/17/2014

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F 323	Continued From page 10 accident hazards from the recliner.	F 323		

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

F5350022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department Of Public Safety, State Fire Marshal Division. At the time of this survey, St. Benedicts Senior Community was found 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This facility was surveyed as two buildings: St. Benedicts Senior Community is a 5-story building with a full basement and an Elevator Equipment Penthouse. The building was constructed at 2 different times. The original building was constructed in 1978 and was determined to be of Type 1(332) construction. In 1997, a 2 story addition was added to the northeast that was determined to be of Type II(111) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 197 beds and had a census of 184 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

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

F535022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING **02 - 2008 ADDITION** B. WING _____	**07/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	**1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304**

(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
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, St. Benedicts Senior Community 2008 addition was found 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) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. St. Benedicts Senior Community Bldg 2 is a 2-story building with no basement. The building was constructed in 2008 and determined to be of Type II(111) construction. The building is fully fie sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, that is monitored for automatic fire department notification. The facility has a capacity of 197 beds and had a census of 184 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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