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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: I90I

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00352

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245459**

2.STATE VENDOR OR MEDICAID NO.
(L2) **787477100**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY WINSTED**
(L4) **551 FOURTH STREET NORTH**
(L5) **WINSTED, MN** (L6) **55395**

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) **02/01/2011**

6. DATE OF SURVEY **09/02/2014** (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 **65** (L18)

13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(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 09/12/2014 (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
04/01/1987
(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.
00320
(L31)

30. REMARKS
Posted 09/22/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/15/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245459

September 24, 2014

Ms. Terry Rieck, Administrator
Benedictine Living Community, Winsted
551 Fourth Street North
Winsted, Minnesota 55395-0750

Dear Ms. Rieck:

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 1, 2014 the above facility is certified for or recommended for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 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

September 12, 2014

Ms. Terry Rieck, Administrator
Benedictine Living Community Winsted
551 Fourth Street North
Winsted, Minnesota 55395-0750

RE: Project Number S5459024

Dear Ms. Rieck:

On August 7, 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 24, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 2, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on August 27, 2014 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 July 24, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 1, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 24, 2014, effective September 1, 2014 and therefore remedies outlined in our letter to you dated August 7, 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.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston

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

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
245459	A. Building B. Wing	9/2/2014

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

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 **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/01/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **09/01/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/01/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **07/28/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	09/12/2014	28595	09/02/2014
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
7/24/2014			

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245459	A. Building B. Wing 01 - MAIN BUILDING 01	8/27/2014

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

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 K0018	08/12/2014	ID Prefix Reg. # NFPA 101 LSC K0067	08/19/2014	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KJ	09/12/2014	28598	08/27/2014
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
7/23/2014			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00352	A. Building B. Wing	9/2/2014

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

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 **20302** Reg. # **MN State Statute 144.6503** LSC	**09/02/2014**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	**09/01/2014**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	**09/01/2014**
ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp. 3** LSC	**09/01/2014**	ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp. 1** LSC	**07/28/2014**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Subd. 4** LSC	**09/02/2014**
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	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	09/12/2014	28598	09/02/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 7/24/2014

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: I90I

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00352

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245459**

2.STATE VENDOR OR MEDICAID NO.
(L2) **787477100**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY WINSTED**
(L4) **551 FOURTH STREET NORTH**
(L5) **WINSTED, MN** (L6) **55395**

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) **02/01/2011**

6. DATE OF SURVEY **07/24/2014** (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 **65** (L18)

13.Total Certified Beds **65** (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
	65			
(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 :
Carol Bode, HFE NE II — 08/26/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 09/10/2014 (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
04/01/1987
(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: **00** (L30)

VOLUNTARY
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.
00320
(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

Certified Mail # 7011 2000 0002 5147 5328

August 7, 2014

Ms. Terry Rieck, Administrator
Benedictine Living Community, Winsted
551 Fourth Street North
Winsted, Minnesota 55395-0750

RE: Project Number S5459024

Dear Ms. Rieck:

On July 24, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

<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 July 24, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 24, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 24, 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 24, 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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

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
	245459	A. BUILDING _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

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F 000	INITIAL COMMENTS The facility's plan of correction will serve as you allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulation has been attained in accordance with your verification.	F 000	F-282 1. R-75 is being turned and repositioned according to the care plan. Nursing staff has been re-educated about the facilities pressure ulcer prevention policy, and the importance of compliance related to the turning and repositioning schedule in R-75's care plan, as well as for all residents' care-planned turning and repositioning schedules. Specific re-education and counseling was completed for NA-H and NA-F on 8/19/14. 2. Other residents having the potential to be affected by the same deficient practice include residents who currently have pressure ulcers, have a Braden score of 18 or less, and/or have co-morbidities that result in increased risk of pressure ulcer formation. Care plans were reviewed for all of these residents and turning and repositioning compliance was verified through the review of daily turning and repositioning documentation completed by registered nursing assistants every shift.	
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the plan of care and provide timely repositioning for 1 of 2 residents, (R75) reviewed with current pressure ulcers. Findings include: R75's diagnoses, identified on the physician order report dated 7/1/2014, included rheumatoid arthritis, and generalized pain. The admission Minimum Data Set (MDS), dated 5/9/2014, identified R75 had intact cognition, was non-ambulatory, and required extensive assistance from staff for bed mobility, dressing,	F 282	8/20/14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/20/14

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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F 282	Continued From page 1 toileting and completing personal hygiene. The Care Area Assessment (CAA) for pressure ulcers, dated 5/15/2014, indicated R75 was admitted with two stage II pressure ulcers (a partial thickness loss of skin, presenting as a shallow, open ulcer, with a red or pink wound bed) on her left, lateral ankle and sacrum. R75's care plan, updated 7/22/2014, identified pressure ulcers, and included various interventions, and directed staff to "...turn and reposition [R75] every hour." During continuous observation on 7/24/2014 from 9:33 a.m. to 11:42 a.m. (2 hours and 9 minutes), R75 was seated in her wheel chair. Nursing assistant (NA)-F assisted R75 with morning cares, and exited her room at 9:33 a.m. At 10:58 a.m., NA-F entered R75's room, assisted with hair grooming, then pushed R75 out of her room and into the main dining room for the mid-day meal. While seated in the main dining room between 11:00 a.m. and 11:30 a.m., R75 was neither off-loaded, nor repositioned in her wheel chair. At 11:33 a.m., following the meal, NA-H assisted R75 back to her room and boosted her in the seat of the wheelchair, using the lift sheet on which she was already sitting. In an interview on 7/24/2014 at 11:42 am, NA-H stated she thought R75 was repositioned just prior to the noon meal by NA-F. On 7/24/2014 at 11:45 a.m., NA-F stated she only combed R75's hair before taking her to the dining room, and acknowledged that R75 was not repositioned since providing her morning cares, at approximately 9:30 a.m, 2 hours and 15 minutes. NA-F said R75 was to be repositioned every hour.	F 282	3. On 8/6/14 and 8/12/14, nursing staff was educated on the importance of remaining in compliance with the entire resident's care plan, including adhering to designated turning and repositioning schedules. Facility also has added an additional intervention to the pressure ulcer prevention policy that states that all nursing assistants are required to carry resident assignment sheets with them when they are working. These resident assignment sheets will reflect resident-specific care plan interventions, including individual turning and repositioning schedules. Education regarding this new policy intervention will be completed on 9/1/14.	

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F 282	Continued From page 2 In an interview on 7/24/2014 an 11:46 a.m., RN-B stated R75 was at risk for developing pressure ulcers, and that the nursing assistants, "should at least be offering and attempting" to turn and reposition her every hour as care planned. In an interview on 7/24/2014 at 1:26 p.m., the director of nursing (DON) stated she would expect, "in the future," that [R75's] care plan be followed. The facility Pressure Ulcer Policy, reviewed 6/2014, indicated as its purpose "To provide for assessment, proper documentation and follow up care for residents that are prone to skin breakdown." Further, the policy listed "repositioning schedules" among preventative measures under the "treatment and management guidelines."	F 282	4. To ensure on-going compliance of care-planned turning and repositioning schedules, DON/Designee will ensure that turning and repositioning schedules are completed according to care plan by auditing compliance for 3 randomly-selected residents who currently have a pressure ulcer and/or are at risk of developing pressure ulcers weekly x6 weeks, then monthly x4 months. To ensure that nursing assistants are carrying resident assignment sheets, Charge Nurse will randomly select 2 nursing assistants each shift to verify that they have their resident assignment sheet with them. These audits will be completed for all 3 shifts daily x7 days, then weekly thereafter on an ongoing basis. Charge Nurse will report findings to DON/Designee. Audit results will be reported in monthly QA meetings x6 months for review and further recommendations. After 6 months, plans will be re-evaluated for continuation or satisfactory compliance. 5. Completion Date: Sept. 1st, 2014	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning to assist in healing pressure ulcers	F 314		

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F 314	Continued From page 3 for 1 of 2 residents, (R75) with current pressure ulcers. Findings include: R75's diagnoses, identified on the physician order report dated 7/1/2014, included rheumatoid arthritis, malnutrition and generalized pain. The initial Minimum Data Set (MDS), dated 5/9/2014, identified R75 had intact cognition, was non-ambulatory, and required extensive assistance from staff for bed mobility, dressing, toileting and completing personal hygiene. The MDS identified R75 had two stage II pressure ulcers (partial thickness loss of dermis, presenting as a shallow, open ulcer, with red-pink wound bed without slough) upon admission. The care area assessment (CAA) for pressure ulcers, dated 5/15/2014, indicated R75 had stage II pressure ulcers located on her left, lateral ankle and sacrum. A skin-tissue tolerance assessment, dated 7/1/2014, indicated R75 was at risk to develop pressure ulcers, needed assistance to reposition and transfer, and that staff was to assist R75 to turn and reposition every one hour while in bed, or in her chair. R75's care plan, updated 7/22/2014, identified pressure ulcers, and included various interventions, among which, directed staff to "...turn and reposition [R75] every hour." During observation of wound care on 7/23/2014 at 7:28 a.m., in R75's room, registered nurse (RN)-B removed, cleansed, then changed the dressing on R75's left lateral ankle. The wound was intact, and surrounding skin was dark red in color. RN-B measured the pressure ulcer which was 1.0 centimeters (cm) x 0.1 cm with no depth.	F 314	F-314 1. R-75's care plan has been reviewed and updated, and R-75 is being turned and repositioned according to the care plan. Due to resident's frequent refusals to be turned and repositioned, a low air loss rotating mattress has been ordered to help ensure turning and repositioning occurs as frequently as it is needed. Facility has also has implemented a reclining wheelchair to assist with pressure redistribution when resident is sitting upright. DON has discontinued the use of pre-moistened wipes for R-75, and care plan reflects the use of dry wipes only to further promote skin integrity. Re-education/counseling was completed for NA-H and NA-F on 8/19/14. 2. Other residents having the potential to be affected include all residents with pressure ulcers, and/or have a Braden score of 18 or less, and/or have co-morbidities that result in increased risk of pressure ulcer formation. Care plans were reviewed for all of these residents and turning and repositioning compliance was verified through the review of daily turning and repositioning documentation done by registered nursing assistants every shift.	

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F 314	Continued From page 4 She cleansed and changed the dressing to R75's right, upper buttock. The wound area was a pink-colored, macerated area, which measured 4 cm x 1 cm, had no depth and was not opened. During continuous observation on 7/24/2014 from 9:33 a.m. to 11:42 a.m. (2 hours and 9 minutes), R75 was seated in her wheel chair. Nursing assistant (NA)-F assisted R75 with morning cares, and exited her room at 9:33 a.m. At 10:58 a.m., NA-F entered R75's room, assisted with hair grooming, then pushed R75 out of her room and into the main dining room for the mid-day meal. While seated in the main dining room between 11:00 a.m. and 11:30 a.m., R75 was neither off-loaded, nor repositioned in her wheel chair. At 11:33 a.m., following the meal, NA-H assisted R75 back to her room and boosted her in the seat of the wheelchair, using the lift sheet on which she was already sitting. In an interview on 7/24/2014 at 11:42 am, NA-H stated she thought R75 was repositioned just prior to the noon meal by NA-F. In an interview on 7/24/2014 at 11:45 a.m., NA-F stated she only combed R75's hair before to taking her to the dining room, and acknowledged that R75 was not repositioned since providing her morning cares, at approximately 9:30 a.m. NA-F said R75 was to be repositioned every hour. In an interview on 7/24/2014 an 11:46 a.m., RN-B stated R75 was at risk for developing pressure ulcers, and that the nursing assistants, "should at least be offering and attempting" to turn and reposition her every hour as care planned. A review of weekly wound documentation in the nursing progress notes from 5/3/2014 to	F 314	3. Turning and repositioning schedules were reviewed for all residents with pressure ulcers, and/or were identified to be at risk for pressure ulcers, to verify that care plans reflect schedules that are effective in healing and/or prevention. To further assist the facility to prevent pressure ulcers, nursing assistants will complete daily skin checks every morning during routine cares for all residents identified to be at-risk, and report any changes and/or unusual findings immediately to a licensed nurse for assessment and review. Licensed nurses will complete weekly skin assessments for these residents, and document assessment findings in resident progress notes. On 8/6/14 and 8/12/14, nursing staff was educated on the importance of remaining in compliance with the entire resident's care plan, including adhering to designated turning and repositioning schedules. Facility has also added an intervention to the pressure ulcer prevention policy that states that all nursing assistants are required to carry resident assignment sheets with them when they are working. These assignment sheets will reflect resident-specific care plan interventions, including turning and repositioning schedules. Education regarding this new policy intervention will be completed on 9/1/14.	

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F 314	Continued From page 5 7/23/2014, indicated R75 had a history of pressure ulcers since admission, and that they were healing: A progress note dated 6/25/2014, read "Sacral wound is resolved. Continues with maceration d/t [due to] loose stools, with 2 pinpoint open areas. Left lateral ankle wound is closed. 1.3 cm x 0.3 cm red/purple scar tissue noted." A progress note dated 7/23/2014, read "Abrasion to right upper buttock caused by moisture closed and intact, pink macerated tissue noted to area...Area of previous pressure ulcer to left lateral ankle remains intact with 1 cm x 0.1 cm of red/purple, fragile appearing tissue." In an interview on 7/24/2014 at 1:26 p.m., the director of nursing (DON) verified R75 should be turned and repositioned every hours to aide in healing R75's pressure ulcers as identified on the skin-tissue tolerance assessment. The facility Pressure Ulcer Policy, reviewed 6/2014, indicated as its purpose "To provide for assessment, proper documentation and follow up care for residents that are prone to skin breakdown." Further, the policy listed "repositioning schedules" among preventative measures under the "treatment and management guidelines."	F 314	4. To ensure on-going compliance of care-planned turning and repositioning schedules, DON/Designee will ensure that turning and repositioning schedules are completed according to care plan by auditing compliance for 3 randomly-selected residents who currently have a pressure ulcer and/or are at risk for pressure ulcers weekly x6 weeks, then monthly x4 months. Audit results will be reported in monthly QA meetings x6 months for review and further recommendations. After 6 months, plans will be re-evaluated for continuation or satisfactory compliance. 5. Completion Date: Sept. 1st, 2014	
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.	F 323		

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F 323	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident who were dependent upon staff, on the secured unit, received adequate supervision while in the day room for 1 of 3 resident (R34) dependent upon staff observed in the dayroom of the secured dementia unit. Findings include: R34's quarterly Minimum data set (MDS) dated 4/14/14 indicated R34's had severe cognitive impairment, and needed total assistance with all activities of daily living. During observation on 7/22/14 at 3:09 p.m. R34 was sitting in her wheelchair, in the dayroom of the secured dementia unit. Her legs of the wheelchair was raised, and was unable to move her hands or self propel her wheelchair. There was a tube feeding pump on a stand next to R34's wheelchair, the tube feeding was running connected to R34. While R34 was sitting, another resident (R90) started to push R34's in her wheelchair out of the day room. R90 pushed R34's wheel chair until the tube feeding tube connected to a separate pole was pulled taught. During this time, R34's eyes became wide opened, her body stiffened and was unable to communicate her needs while R90 was pushing her wheelchair. R90 continued pushing R34's until licensed practical nurse (LPN)-B who was	F 323	F-323 1. All residents on the secured dementia unit are adequately supervised. The dayroom on the secured unit has been re-arranged to alleviate agitation of R-90 in relation to the location of other residents. Birdcage was also relocated to be less visible to R-90. An IV pole for tube feedings that can be secured to the wheelchair has been ordered for R-34 to resolve any risk of reoccurrence. Care plans for R-34 and R-90 were also updated to reflect these interventions. 2. Facility has identified that any wheelchair bound resident on the secured dementia unit who is dependent upon staff and also requires external care measures that are not secured to the resident's body or wheelchair as at risk to be affected by the deficient practice. These residents and their care plans have been reviewed for safety.	

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F 323	Continued From page 7 walking by, was summoned by the surveyor to assist R34. LPN-B moved R34 away for R90 and stated R90 does not like other people near her favorite chair and should not have placed R32 in that space. During an interview on 7/23/14 at 7:22 a.m. LPN-C "R34 is unable to speak but her family does speak to her in a different language. R34 communicate with the facility staff by blinking her eyes if she wants something, or if she gets restless. An interview on 7/23/14 at 1:21 p.m. registered nurse (RN)-C stated the problem is because R90 is very territorial of her chair and doesn't want anyone around her chair in the day room. Someone put R34's wheelchair in front of her chair and she doesn't like it. Last week R34 was put in front of R90's chair to watch the birds and R90 started to shake R34 's chair. Staff moved the bird cage so R34 can watch the birds and not bother R90. RN-C stated, this was care planned in R90's record that we should not put anyone in front or around the chair she likes. R90 does not understand staff because of her cognitive condition, so they avoid placing anything by R90's chair. Review of R34's care plan updated 7/21/14 identified a problem with resident being susceptible related to her inability to care for self, poor communication and language barrier. Staff were directed to follow the plan of care to ensure safety, identify risk factors for vulnerability, observe and document changes in mood/behavior, and provide a safe environment for resident and others as needed. There was no indication in the care plan to not place R34 near	F 323	3. For all residents identified to be at risk for this deficient practice, a means to secure equipment to resident's wheelchair or body has been established. On 8/6/14 and 8/12/14, all nursing staff was educated about the importance of routine supervision and taking a proactive approach in promoting a safe environment for all residents, especially those who are entirely dependent upon staff. 4. 1st Floor Clinical Manager will audit the location of all residents for safety in proximity to the birdcage twice daily x7 days, then once weekly x5 weeks, then monthly x4 months. Audit results will be reported in monthly QA meetings x6 months for review and further recommendations. After 6 months, plans will be re-evaluated for satisfactory compliance. 5. Completion Date: Sept. 1st, 2014	

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F 323	Continued From page 8 R90's chair. During an interview on 7/24/14 at 10:08 a.m. the DON stated, "[R90] pretty territorial about her space." Staff had moved the bird cage because it was a problem. The DON said we have trained staff regarding the care plan changes and discussed these in their daily team meeting. The DON confirmed there needs to be better oversight in this area. A review of R90's care plan indicated, not to put anyone in front of R90's favorite chair.	F 323		
F 441 SS=F	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. (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	F 441		

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F 441	Continued From page 9 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 linens were washed appropriately to reduce the risk of infection and contamination. This had potential to affect 59 residents who's linens were washed with the facility machines. Findings Include: During observation of the facility laundry room(s), on 7/24/14 at approximately 8:05 a.m., there were two UniMac cylinder washing machines with linens being washed. During the same observation, the smaller machine had a digital outside thermometer that read 0.0 F (degrees in Fahrenheit) while the machine was in the wash cycle. During interview on 7/24/14, at 8:14 a.m.,	F 441	F441 1. The water source to the two washing machines is supplied by a dedicated water heater. Maintenance checks the water temperatures of the water heater daily. The machine with the inaccurate temperature read out was repaired on 7/28/14 and now reads accurate temperatures. 2. All residents have the potential to be affected by inaccurate washing temperatures. 3. The temperature read out on the machine will be recorded weekly and noted on a clipboard. Water temperatures will continue to be monitored by maintenance/Environmental Director.	

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F 441	Continued From page 10 personal laundry assistant (PLA)-A stated the smaller washing machine must be broken. PLA-A stated the wash temperatures of the machines are not checked daily, nor was PLA-A aware of any formal process for auditing or monitoring the washing machines function or temperature during the wash cycles. PLA-A stated she was unsure if maintenance completed any monitoring of the machines function or water temperatures. Further, PLA-A stated all linens, including linen from isolation rooms, were washed in the two washing machines observed, and again stated she wasn't sure how hot the water got during the wash cycles. PLA-A was not aware how to check the wash temperature of the larger UniMac machine. When interviewed on 7/24/14, at 8:33 a.m., environmental services director (ESD)-A stated the temperature display for the smaller machine was malfunctioning, and was unaware of how long it had not been working. ESD-A stated there was no formal process to verify the wash temperatures are reaching the required levels to promote killing of bacteria and viruses. ESD-A stated Sunburst Chemical services the machines when they need repair, and also completes routine audits on the laundry process, including the washing machine temperatures. ESD-A further stated the machines wash cycles should have temperatures of at least 160 degrees, "to meet infection control standards." ESD-A also was not aware how to check the wash temperature of the larger UniMac machine. A telephone interview 7/24/14, at 8:54 a.m. with a representative of Sunburst Chemical stated their	F 441	4. Plant Operations Manager or designee will report to the Safety Committee on a monthly basis who will in turn, report to the Quality Assurance Committee on a monthly basis x6 months, and will then be re-evaluated for continuation or satisfactory compliance. 5. Completion Date: July 28th, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

(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 441	Continued From page 11	F 441		

company merely services the chemical dispensing units and does not complete any audits on the washing machines themselves. Further, the representative stated water not reaching 160 degrees would pose an infection control concern.

The facility Laundry Service Report, dated 7/7/14 which was completed by Sunburst Chemical, identified the facility had no issues with the laundry service. The report further identified two washing machines were being used, however the report identified an "NA" (not applicable) written in the space of washing temperatures or pH (a figure expressing the acidity or alkalinity of a chemical) section of the form.

During interview on 7/24/14, at 9:19 a.m., plant operations manager (POM)-A stated the facility uses a high temperature washing process in their washing machines. POM-A stated he believed ESD-A completed a weekly water temperature audit during the washing cycles.

When interviewed on 7/24/14, at 10:23 a.m., the director of nursing (DON) stated the lack of water temperature monitoring poses an infection control concern. Further, the DON stated all bed linens were washed in the two machines observed.

The manufacturer's instruction's for the two washing machines were requested, but none were provided.

An un-dated Linen Handling and Treatment To

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING _____ B. WING _____	07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

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F 441	Continued From page 12 Prevent The Spread Of Infection policy indicated a purpose of "...assure linen is sorted, washed, dryed, delivered and handled on the resident units to promote infection control." Further, the policy indicated laundry is to be washed at a temperature of 160 degrees or higher for 25 minutes to destroy microorganisms.	F 441		

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

F5459073

PRINTED: 08/07/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

(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 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 July 23, 2014. At the time of this survey, Building 01 of Benedictine Living Community Winsted was found not 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 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 Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	POC ok JB 8-25-14 RECEIVED AUG 25 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 9-2-14

EXIT: 7-24-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Admin	8/20/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/23/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	**551 FOURTH STREET NORTH WINSTED, MN 55395**

(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	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 01 of Benedictine Living Community Winsted consists of the original 1960 building. It is two-stories in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type I(332) construction. The facility 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 has a licensed capacity of 65 beds and had a census of 59 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core	K 018		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/23/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	**551 FOURTH STREET NORTH** **WINSTED, MN 55395**

(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 018	Continued From page 2 wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and a staff interview, one or more corridor doors failed to positively latch into their frames. In a fire emergency, this deficient practice could adversely affect 25 of 65 residents in Building 01. FINDINGS INCLUDE: On 07/23/2014 at 2:35 PM, observation revealed the double doors leading into the First Floor Family Room did not positively latch into the frame, as the manual flush bolt on the inactive door leaf had not been activated. This finding was verified with the chief building engineer at the time of discovery.	K 018	K018 1. Door was adjusted to latch properly on 8/12/14 by Plant Operations Manager. 2. Plant Operations Manager or designee will monitor door for correct latching for four weeks and will report monthly to Safety Committee for continued compliance. QA Committee will review during monthly meetings for 6 months and recommend continuation or satisfactory compliance. 3. Completion Date: Aug. 12th, 2014.	
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/23/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	**551 FOURTH STREET NORTH WINSTED, MN 55395**

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K 067	Continued From page 3 Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and a staff interview, it could not be verified whether the facility's general ventilating and air conditioning system (HVAC) was maintained in accordance with NFPA 101 (2000) Chapter 19, Section 19.5.2.1 and Chapter 9, Section 9.1 and NFPA 90A [1999]. In a fire emergency, a noncompliant HVAC system could adversely affect 45 of 65 residents in Building 01. FINDINGS INCLUDE: On 07/23/2014 at 12:55 PM, during an interview with facility staff, it was confirmed the HVAC system does contain one or more fire/smoke dampers, however, no documentation could be provided verifying the fire/smoke dampers were inspected and tested within the previous 4 years, in accordance with NFPA 90A [1999] Chapter 3, Section 3-4.7. This finding was confirmed with the chief building engineer.	K 067	KO067 1. Smoke dampers will be inspected and tested on 8/19/14. 2. Plant Operations Manager now has dampers on a 4 year preventative maintenance schedule with Gilbert Mechanical. 3. Completion Date: Aug. 19th, 2014.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING **02 - NEW MAIN ENTRANCE** B. WING _____	**07/23/2014**

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, on July 23, 2014. At the time of this survey, Building 02 of Benedictine Living Community Winsted 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 Occupancies. Building 02 of Benedictine Living Community Winsted was constructed in 2011, is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction. The facility 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 has a licensed capacity of 65 beds and had a census of 59 at time of the survey.	K 000		

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

Admin | 8/20/14

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Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5328

August 7, 2014

Ms. Terry Rieck, Administrator
Benedictine Living Community, Winsted
551 Fourth Street North
Winsted, Minnesota 55395-0750

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5459024

Dear Ms.. Rieck:

The above facility was surveyed on July 21, 2014 through July 24, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to Brenda Fischer, Unit Supervisor at Minnesota Department of Health, 3333 W Division, #212, St Cloud MN, 56301. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call Brenda Fischer 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