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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: J4YF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 29890

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245623**

2.STATE VENDOR OR MEDICAID NO.
(L2) **103600300**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING CTR FRIDLEY**
(L4) **520 OSBORNE ROAD NORTHEAST**
(L5) **FRIDLEY, MN** (L6) **55432**

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 **06/06/2016** (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)
06/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (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
	50			
(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 :
Susanne Reuss, Unit Supervisor 06/06/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 06/28/2016 (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
03/18/2015
(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.
00000
(L31)

30. REMARKS
Posted 07/14/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/07/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245623
June 28, 2016

Ms. Mary Nell Zellner, Administrator
Benedictine Living Center, Fridley
520 Osborne Road Northeast
Fridley, Minnesota 55432

Dear Ms. Zellner:

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 May 31, 2016 the above facility is certified for or recommended for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

June 7, 2016

Ms. Mary Nell Zellner, Administrator
Benedictine Living Ctr Fridley
520 Osborne Road Northeast
Fridley, MN 55432

RE: Project Number S5623001

Dear Ms. Zellner:

On May 3, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 21, 2016. 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 June 6, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 21, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 30, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 21, 2016, effective May 31, 2016 and therefore remedies outlined in our letter to you dated May 3, 2016, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245623 Y1	A. Building B. Wing Y2	6/6/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CTR FRIDLEY	520 OSBORNE ROAD NORTHEAST FRIDLEY, MN 55432

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0278	Correction	ID Prefix F0281	Correction	ID Prefix F0371	Correction
Reg. # 483.20(g) - (j)	Completed	Reg. # 483.20(k)(3)(i)	Completed	Reg. # 483.35(i)	Completed
LSC	05/31/2016	LSC	05/31/2016	LSC	05/31/2016
ID Prefix F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/31/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	SR/kfd	6/14/2016	16022	6/6/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/21/2016

☐ 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: J4YF

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(L1) **245623**

2.STATE VENDOR OR MEDICAID NO.
(L2) **103600300**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING CTR FRIDLEY**
(L4) **520 OSBORNE ROAD NORTHEAST**
(L5) **FRIDLEY, MN** (L6) **55432**

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 **04/21/2016** (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)
06/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

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

X 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: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(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 :
Momodou Fatty, HFE NE II 05/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 06/02/2016 (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
03/18/2015
(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.
00000
(L31)

30. REMARKS
Posted 06/07/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 5934
May 3, 2016

Ms. Mary Nell Zellner, Administrator
Benedictine Living Center Fridley
520 Osborne Road Northeast
Fridley, Minnesota 55432

RE: Project Number S5623001

Dear Ms. Zellner:

On April 21, 2016, 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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

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 May 31, 2016, 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 May 31, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (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 July 21, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 21, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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. Tom Linhoff, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245623	A. BUILDING _____ B. WING _____	04/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CTR FRIDLEY	520 OSBORNE ROAD NORTHEAST FRIDLEY, MN 55432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	ser 5/25/16	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each	F 278	**F278** The MDS assessment incongruities with medical record documentation will be audited and managed through a secondary software package called Point Right. This software identifies any coding inconsistencies with each MDS. Resident R65 and R3's where under coded which did not result in a chance in RUGs scoring or reimbursement. The two MDS Nursing staff members have been educated on the expectations of accuracy of their work, coding documentation, and submissions by the Director of Nursing. The Director of Nursing will monitor the Point Right software reports weekly to assure compliance and consistency of MDS coding. May 27, 2016	

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

TITLE: Administrator

(X6) DATE: 5/17/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245623	A. BUILDING _____ B. WING _____	04/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CTR FRIDLEY	520 OSBORNE ROAD NORTHEAST FRIDLEY, MN 55432

(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 278	Continued From page 1 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to accurately code pressure ulcers on the Minimum Data Set (MDS) for 1 of 2 residents (R65) reviewed for pressure ulcers. In addition, the facility failed to accurately code activities of daily living (ADLs) on the MDS for 2 of 3 residents (R65, R3) reviewed for ADLs. Findings include: R65's admission/5 day MDS dated 3/18/16, was not coded to indicate R65 had a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device, however did indicate that resident had one Stage 2 pressure ulcers and one Stage 2 pressure ulcers that were present upon admission/entry or reentry. In addition, R65's 14 day MDS dated 3/23/16 was not coded to indicate R65 had stage 2 pressure ulcer and did not indicated R65 had pressure ulcers present on the prior assessment (OBRA or scheduled PPS. Furthermore, R65's discharge MDS dated 3/31/16 was not coded to indicate R65 had stage 2 pressure ulcer and did not indicated R65 had pressure ulcers present on the prior assessment (OBRA or scheduled PPS. R65's Progress Note dated 3/16/16 at 4:18 p.m. revealed, "Weekly wound note - ... Guest continues with skin impairment to coccyx region.	F 278		

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	245623	A. BUILDING _____ B. WING _____	04/21/2016

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F 278	Continued From page 2 Guest reports "area has been there for years, you (Interlude staff) are the first to pay attention to it (impairment). Area measures 2x0.5cm. 1005 granulation present. scant amount of serosanguineous drainage present. No odor. Wound edges are intact and pink. Peri wound is intact, pink and blanchable. No SOI. Denies pain at site. Interventions in place reviewed, Guest verbalized understanding and repots compliance. Nursing to continue with current treatment and will continue to monitor until areas are healed." R65's Progress Note dated 3/23/16 at 4:46 p.m. indicated, "Weekly wound note - Guest continues with impairment to coccyx region. Area measures 1.6x0.3cm. Improvement noted. 100% granulation. Area is a slit. No drainage or odor noted. wound edges are pink. Peri wound is per normal skin and blanchable ..." R65's Progress Note dated 3/30/16 at 6:08 p.m. read, "... Contnues [continues] with minimal impairment to coccyx region. Slit measures 0.3x0.1 cm. 100% granulation. No drainage or odor noted. Wound edges are pink. Peri wound is intact and blanchable. No SOI. Denies pain at site. Nursing to continue with current treatment and continue to monitor area." R65's Skin Assessment dated 3/11/16 at 11:00 p.m. revealed, "... Guest had mepilex dressing on coccyx area that writer removed and observed slight skin breakdown, new dressing applied..." R65's care area assessment (CAA) dated 3/22/16, noted, "admitted with pressure ulcer stage II on coccyx. 5cm x 1.5cm ... is aware of area on coccyx and states "its [it's] been there a long time but no one ever does anything about it". had dressing on admit. is at risk for skin breakdown r/t poor state of health, chronic anemia, currently admitted with stage II pressure ulcer on coccyx and low weight with poor	F 278		

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F 278	Continued From page 3	F 278		

appetite. has freq [frequently] urine and bowel incont [incontinent] and dep on staff for management. has measures in place to prevent further skin breakdown. Braden scale score of 1 does not indicate a risk but with all things considered she is a risk assist with turn and repositioning q 2 hrs [hours] in conjunction with toileting. pericare with each incont. tx [treatment] as ordered to coccyx. pressure reduction mattress and cushion."

Temporary Care Plan: undated reads, indicated that "Yes" for coccyx wound.

On 4/19/16 at 2:14 p.m. registered nurse (RN)-A, confirmed R65 was admitted with stage 2 pressure ulcer and was discharge with stage 2 pressure ulcer and indicated, "The pressure ulcer was almost healed prior to discharge."

On 4/19/16 at 2:24 p.m. RN-B (the facility's MDS coordinator), also reviewed the resident's medical records that includes the MDS, progress notes, etc. RN-B verified the Stage 2 coccyx pressure ulcers had not been coded on the MDS accurately. RN-B stated, "The admission MDS dated 3/18/16, M0100A should have been checked. The 14 day MDS 3/23/16 M0100A and M0210 should have been checked as well. I will do corrections on all."

On 4/19/16 at 2:50 p.m. the director of nursing, stated, "Our goal is to code the MDS accurately according to the RAI manual. The MDS coordinator comes to our weekdays (Mondays through Fridays) meeting and we update them of resident condition."

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F 278	Continued From page 4 R65 was admitted to the facility on 3/11/16, with diagnoses of hypertension, heart failure, and atrial fibrillation. Admission/5 day Minimum Data Set (MDS) dated 3/18/16, indicated extensive assistance with transfer. Point of Care history (POC) for transfers dated 3/11/2016 - 3/18/2016, indicated limited assistance with transfers 3,/12, 3/13, 3/14, 3/15, 3/16, 3/17, and 3/18. Two dates of 3/11/16, and 3/12/16, indicated extensive assistance. Care Area Assessment (CAA) dated 3/18/16, indicated extensive assistance with transfers. Temporary Care Plan with admit date of 3/11/16, indicated assist of one with transfers. On 4/21/16, at 12:59 p.m. registered (RN)-B confirmed R65's transfers should have been coded as limited assist of one, not extensive assist. RN-B further stated she would not modify the record because R65 had been discharged and it would not change the pay source. On 4/21/16 at 1:34 p.m. director of nursing (DON) stated her expectation was the MDS should be coded accurately. When we find an error the correction should be made. R3 was admitted to the facility on 12/24/15, with diagnoses of hypertension, type II diabetes mellitus and chronic kidney disease. Admission/5day MDS dated 12/31/15, indicated set up help only one person assist for bed mobility. POC for transfers dated 12/24/2105 - 12/31/2015, indicated limited assistance with bed	F 278		

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F 278	Continued From page 5 mobility 12/26, 12/29, and 12/31/15. CAA dated 1/15/16, indicated supervision with bed mobility. Temporary care plan with admit date of 12/24/15, indicated independent with mobility. On 4/21/16 at 12:57 p.m. RN-B confirmed R3's bed mobility should have been coded limited assist of one instead of supervision with assist of one. RN-B further stated she would not modify the record because R3 had been discharged and it would not change the pay source. On 4/21/16, at 1:35 p.m. DON stated her expectation was to code the MDS accurately and make corrections per RAI guidelines. CMS's RAI Version 3.0 Manual dated October 2014 directed: "Steps for Assessment 1. Review the documentation in the medical record for the 7-day look-back period. B. Transfer: how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet)." "The Rule of 3 In order to properly apply the Rule of 3, the facility must first note which Activities of Daily Living (ADL) activities occurred, how many times each ADL activity occurred, what type and what level of support was required for each ADL activity over the entire 7-day look-back period."	F 278		

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F 278	Continued From page 6 "Instructions for the Rule of 3: When an ADL activity has occurred three or more times, apply the steps of the Rule of 3 below (keeping the ADL coding level definitions and the above exceptions in mind) to determine the code to enter in Column 1, ADL Self-Performance .... 1. When an activity occurs three or more times at any one level, code that level. "	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a temporary comprehensive care plan that included potential for bruising, due to the use of anti-coagulant medications, for1 of 3 residents (R206) reviewed for non-pressure related skin conditions. Findings include: R206 admitted to the facility 4/9/16 and discharged 4/21/16. Diagnoses, identified on the Physician Order Report included heart disease. The Physician Orders indicated R206 was receiving Plavix (a medication that is used to prevent blood clots) and Aspirin. R206's medical record was reviewed and revealed a document titled "ADMISSION BODY AUDIT: SKIN CONDITION" dated 4/9/16, the document indicated that R206 had bruises on the	F 281	**F281** Resident F206 had discharged prior to the conclusion of the survey therefore his care planning and care plan could not be updated prior to receipt of the Statement of Deficiencies. The survey team audited 100% of the in-house facility medical records and no other care planning documentation was found to be lacking on the short-term/temporary care planning or the full care plans of the Interlude Restorative Suites guests. Admission skin assessment will be placed in pass through area within each guest suite for reference by staff to identify any new skin impairments.	

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F 281	Continued From page 7 upper right arm, a reddened bruise on the left forearm and a skin tear on right elbow. R206's care plan dated 4/9/16, indicated that R206 had a braden score (a tool used to predict pressure ulcer risk) of 20 and had an incision on his left knee. The care plan further indicated R206 required staff assistance with dressing, bathing, transfers, toileting and required set up for grooming. The care plan did not identify that R206 received Plavix and Aspirin and had the potential to bruise easily. R206 was observed on 4/18/16, at 3:37 p.m. sitting on the edge of his bed wearing a short sleeved shirt. Multiple dark bluish/purple areas on bilateral forearms and on posterior aspect of both hands were observed. In a follow-up observation on 4/20/16, at 1:24 p.m. R206 was observed sitting in wheelchair in his room, wearing a short sleeved shirt, bluish/purple areas to bilateral forearms and posterior aspect of both hands were visible. When interviewed, R206 explained that he was on a blood thinner and that the discolored areas were probably from bumping into things and has had them on both hands and forearms for a long time. Registered nurse (RN)-D was interviewed on 4/20/16, at 1:11 p.m. and stated R206 required staff assistance with transfers and ambulation. RN-D acknowledged that R206 had discolored areas on bilateral forearms and posterior aspect of both hands, and explained, "he has had those since he came, he takes a blood thinner medication".	F 281	The Admission Coordinators will be accountable to initiate the guest care plan upon admission. Clinical Managers will audit and update care plans on an ongoing basis for any needed changes. The Nursing Supervisors will conduct weekly audits for two weeks x 5 employees, then monthly for two months x 5 employees on multiple shifts to audit for compliance. May 30, 2016	

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F 371 F 371 SS=F	Continued From page 8 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the waffle maker, the toaster, and two stoves in a sanitary manner. In addition the facility failed to date food items when opened that were stored in the refrigerator and in storage cabinets. This had the potential to affect all 30 residents who ate out of the facility kitchen. Findings include: On 4/18/16, at 12:09 p.m. an initial tour of the facility kitchen was conducted with the facility's director of culinary services (DCS). The following concerns were observed on the 2nd and 3rd floor kitchen: - The waffle maker was noted with greasy dark black/brown grime buildup on the inside, along the edges and on the outside of the waffle maker. - The toaster was noted with bread crumbs at the bottom and debris all over. During a follow up kitchen tour of 4/19/16, from 1:08 p.m. to 2:00 p.m. with the DCS. The	F 371 F 371	**F 371** A daily cleaning schedule will be implemented on 5/16/16 that lists tasks that need to be done each day. This sheet is signed when completed and turned into the Director of Culinary Service at the end of each shift. This will be filled and kept for 1 year. To ensure compliance audits will occur according to the following schedule; daily audit for one week from 5/16/16-5/23/16, followed by once a week audits from 5/23/16-5/30/16. These audits will be completed by the Director of Culinary Service or Lead Chef. To sustain compliance twice monthly audits these will be completed on the cleaning schedule and food dating by the Director of Culinary Service or Lead Chef. Corrective action will be provided through re-education with all culinary staff to be completed 5/16/16 and 5/18/16 to account for all employees. This document will be signed and will include the cleaning schedule and food dating expectation. May 30, 2016	

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F 371	Continued From page 9 following concerns were observed and verified by the DCS: 1st floor Kitchen - The four burner stove was noted with thick build up of black/brown grime dirt build up all around the surfaces of the four burners and on the handle knobs. The DCS verified that the stove was not kept clean. When asked how often the stove is cleaned the DCS stated that the stove is cleaned weekly and whenever visibly dirty. 2nd floor Kitchen - The waffle maker was noted with greasy dark black/brown grime buildup on the inside, along the edges and on the outside of the waffle maker. The DCS verified that the waffle maker was not clean and stated that it needed to be cleaned. - The toaster was noted with bread crumbs at the bottom and debris all over. The DCS verified that the toaster was not clean and stated that it needed to be cleaned. - Two undated plastic containers that contained cold cereal were observed in a storage cabinet above the sink, one container was labelled rice chex and the other container labelled honey nut. The DCS verified that the plastic containers were undated and stated the plastic storage containers should be dated when cereal was poured into them from the original package. - The four burner stove was noted with thick build up of black/brown grime dirt build up all around the surfaces of the four burners and on the handle knobs. 3rd floor Kitchen - The waffle maker was noted with greasy dark black/brown grime buildup on the inside, along the edges and on the outside of the waffle maker. The DCS verified that the waffle maker was not clean and stated that it needed to be cleaned.	F 371		

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F 371	Continued From page 10 - The toaster was noted with bread crumbs at the bottom. The DCS verified that the toaster was not clean and stated that it needed to be cleaned. - Undated and unlabelled plastic container that contained a creamy liquid substance was observed inside the large refrigerator. The DCS asked cook (C)-A what the liquid substance in the refrigerator was and C-A stated was mushroom soup. The DCS verified the storage container was unlabelled and undated. The DCS stated items that are stored in the refrigerator should be labelled and dated when placed in the refrigerator. - Undated opened brown bag that contained ash browns was observed stored in the small refrigerator. The DCS verified that the brown bag was open and undated. The DCS stated staff are to date all food items stored in the refrigerator when opened. A facility's cleaning kitchen equipment policy dated 1/1/15, directed staff to shake the toaster to knock all the crumbs to the crumb tray, remove the crumb tray, to wash it with soap and water, and to wipe the outside of the toaster daily and after each use. The food storage policy dated 1/1/15 directed that all food products not in their original containers will be placed in seamless, tightly sealed containers labelled and dated for storage. The policy further directed all food stored in the refrigerator should be stored in seamless containers with a use by date.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		

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F 441	Continued From page 11 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 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 hand washing	F 441	**F441** Staff members are trained upon hire and annually on the steps of proper hand washing. In addition, clinical staff members receive annual education through Educare software training on hand washing and proper infection control practices. The survey found one instance of one nursing assistant failing to wash her hands in between changing gloves. The nursing assistant was coached regarding her hand washing omission in between glove changes. It was reported by Employee M-A, that the storage of the items in the in the guest laundry room were both in separate enclosed plastic bags. The soiled linen was in an enclosed and sealed plastic laundry bag. The clean bedspreads were located in a plastic bag placed inside of a laundry basket. It is deemed by the Building Operations Director and the Administrator that there no cross contamination possible for any of the clean linens due to being enclosed in plastic bags.	

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F 441	Continued From page 12 between glove changes for 1 of 1 residents (R186) reviewed for infection control. In addition, the facility failed to ensure proper separation of soiled and clean linen in the 2nd floor laundry/clean room. Findings include: R186's occupational therapy plan of care indicated R186 was receiving treatment of generalized muscle weakness. The plan of care also listed diagnoses that included chest pain, diabetes and unstable angina. R186's admission Minimum Data Set (MDS), dated 4/5/16, indicated R186 was had moderately impaired cognition, required extensive assistance with bed mobility and was frequently incontinent of bladder and bowel. During an observation on 4/20/16, at 7:27 a.m., nursing assistant (NA)-A entered R186's room. NA-A closed the door, turned on the overhead light and donned gloves. NA-A pulled a garbage can close to the bed and raised the bed. NA-A asked R186 to roll to one side, tucked a clean chuck under R186, removed her brief and put clean, dry towels on the chuck. NA-A then went to the bathroom, wet a two washcloths with warm water and added soap to one washcloth. NA-A put these on a clean garbage bag and brought them to the bedside. NA-A then washed R186's peri area, front to back, using the soapy wash cloth, then the wet one to rinse and a dry towel to dry. NA-A put the used washcloths and towels in the bag, and without changing gloves applied barrier cream to R186's buttocks. NA-A then removed her gloves, and donned clean gloves with hand hygiene in between. NA-A then applied	F 441	The Nursing Supervisors will be accountable to monitor for proper storage of dirty linen to the chutes versus being held in the laundry room. The Nursing Supervisor will conduct weekly audits for two weeks x 5 employees, then monthly for two months x 5 employees on multiple shifts to audit for compliance. Results will be reported to the QA Committee for direction if additional monitoring and training is deemed necessary. May 30, 2016	

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F 441	Continued From page 13 a clean incontinence product to R186, adjusted R186's pillows, lowered the bed, and put a fresh bag in the garbage. NA-A removed her left glove, took the barrier cream to the bathroom counter, opened the room door and using her non-gloved hand, pushed the code for the soiled utility room. NA-A confirmed she did not perform hand hygiene between glove changes or before leaving R186's room. NA-A stated she did perform hand hygiene in the soiled utility room, but not before. In an interview on 4/20/16, at 2:37 p.m., the director of nursing (DON) stated they expect staff to wash their hands before donning gloves, and between glove changes. In addition, the DON stated they expect staff to wash their hands before leaving a resident's room and again after disposing of a bag of soiled laundry in the soiled utility room. In an interview on 4/20/16, at 9:20 a.m., the Maintenance Director (M)-A stated each floor has a laundry room where the night aides wash personal linens. The M-A stated that facility linens (sheets, towels, washcloths, etc.) are put down the chute and cleaned by a co-op offsite laundry three times a week. During the tour on 4/20/16, at 9:20 a.m., a plastic bag of soiled facility linen was observed on the floor of the second floor guest laundry room. This bag of soiled linen was touching a laundry basket that held 3 bedspreads, also in plastic bags. M-A confirmed that the bag of soiled linen should not have been left on the floor, especially touching containers and bags of clean bedspreads.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245623	A. BUILDING **01 - BENEDICTINE LIVING CENTER FRIDLEY** B. WING _____	**04/22/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CTR FRIDLEY	**520 OSBORNE ROAD NORTHEAST FRIDLEY, MN 55432**

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K 000	INITIAL COMMENTS FIRE SAFETY An Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on April 22, 2016. At the time of this survey, Benedictine Living Center of Fridley 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. Benedictine Living Center of Fridley is a 3-story building without a basement. The building was constructed in 2014 and was determined to be of Type II(111) construction. The building is has a full fire sprinkler system in accordance with NFPA 13, 1999 Ed. The facility has a fire alarm system with smoke detection in the corridors, by the smoke barrier doors, resident rooms and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 50 beds and had a census of 27 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.