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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: K7Z8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00399

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

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

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

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

6. DATE OF SURVEY **01/02/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Thomas Linhiff, DSFM 01/16/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/17/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/01/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5501

A follow up of the Life Safety Code deficiency K0052 and K0056 from the July 31, 2014 standard survey, which had been recommended for a temporary waiver with a date of completion of December 31, 2014, was completed on January 2, 2015 and found corrected. Refer to the CMS 2567b for results of this revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 16, 2015

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

RE: Project Number F5501022

Dear Ms. Nelsen:

On August 25, 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 31, 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 30, 2014, we notified you that based on our follow-up visit completed on September 15, 2014; we determined that your facility had corrected the deficiencies issued pursuant to our August 25, 2014 standard survey, effective September 24, 2014. On September 30, 2014 we also informed you that we had recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office that approval of your request for a temporary waiver involving the Life Safety Code deficiencies cited at K52 and K56, including the date of completion of December 31, 2014, had been approved.

A follow-up of the remaining Life Safety Code deficiencies cited at K52 and K56 was completed on January 2, 2015 and the deficiencies were found to be corrected as of December 31, 2014. Enclosed is a copy of the Post Certification Revisit Form (CMS-2567B) from this visit.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

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 A. Building B. Wing	(Y3) Date of Revisit
245501	02 - NEW BUILDING	1/2/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0052	12/31/2014	ID Prefix Reg. # NFPA 101 LSC K0056	12/31/2014	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/KFD	01/16/2015	12424	01/02/2015
CMS RO				

Followup to Survey Completed on: 7/29/2014

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: K7Z8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00399

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

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

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

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

6. DATE OF SURVEY **09/15/2014** (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 **79** (L18)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Documentation supporting the facility's request for a temporary waiver for K52 and K56 with a completion date of 12/31/2014, has been approved.

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 10/01/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/10/2014 (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
11/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/01/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245501

October 10, 2014

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

Dear Ms. Nelsen:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 24, 2014 the above facility is certified for:

79 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

September 30, 2014

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

RE: Project Number S5501024

Dear Ms. Nelsen:

On August 25, 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 31, 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 15, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 29, 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 31, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 24, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 31, 2014, effective September 24, 2014 and therefore remedies outlined in our letter to you dated August 25, 2014, will not be imposed.

Correction of the Life Safety Code deficiencies cited under K52 and K56 at the time of the July 31, 2014 standard survey, has not yet been verified. Your plan of correction for these deficiencies, including your request for a temporary waiver with a date of completion of December 31, 2014, have been approved.

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, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

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
245501	A. Building B. Wing	9/15/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0164 Reg. # 483.10(e), 483.75(l)(4) LSC	09/09/2014	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	09/09/2014	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	GPN/KFD	10/01/2014	10160	09/15/2014
CMS RO				

Followup to Survey Completed on: 7/31/2014

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245501	A. Building B. Wing **02 - NEW BUILDING**	9/29/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **09/09/2014**	ID Prefix	Correction Completed **09/05/2014**	ID Prefix	Correction Completed **09/24/2014**
Reg. # **NFPA 101** LSC K0011		Reg. # **NFPA 101** LSC K0018		Reg. # **NFPA 101** LSC K0027	
ID Prefix	Correction Completed **08/28/2014**	ID Prefix	Correction Completed **08/28/2014**	ID Prefix	Correction Completed **07/29/2014**
Reg. # **NFPA 101** LSC K0029		Reg. # **NFPA 101** LSC K0050		Reg. # **NFPA 101** LSC K0076	
ID Prefix	Correction Completed **08/28/2014**	ID Prefix	Correction Completed **08/28/2014**	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0143		Reg. # **NFPA 101** LSC K0147		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/KFD	09/30/2014	32978	09/29/2014
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
7/29/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: K7Z8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00399

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

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

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

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

6. DATE OF SURVEY **07/31/2014** (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 **79** (L18)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Pamela Manzke, HFE NE II 09/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/30/2014 (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
11/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN-24-5501

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F). Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

Documentation supporting the facility's request for a temporary waiver cited at K52 & K56 with a completion date of 12-31-2014 had been approved.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3055 0578

August 25, 2014

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

RE: Project Number S5501024

Dear Ms. Spike:

On July 31, 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:

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:

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, MN 56258
Kathryn.serie@state.mn.us
Office: (507) 537-7158
Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 9, 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 September 9, 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 31, 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 31, 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,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Monday, September 15, 2014 9:31 AM
To: Jan.Suzuki@cms.hhs.gov
Cc: tom.linhoff@state.mn.us; 'Linda Nelsen'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject: Benedictine Living Community of St Peter (245501) Requst for Temporary Waivers for K52 & K56

This is to inform you that I am accepting Benedictine Living Community of St Peter's request for temporary waivers until 12-31-14 for K52, addition of a smoke detector over the fire alarm panel, and K56, addition of fire sprinkler heads under a HVAC duct.

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

Name of Facility **2000 CODE**

Benedictine Living Community of St. Peter, 245501, St. Peter, MN

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K. 052 A temporary waiver is requested for a fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72.	A temporary waiver for K052 is being requested until 12-31-14. A. A temporary waiver for K052 is needed because: 1. The original contractor is no longer in business and the programming is locked out. To install an additional smoke detector will require connection to the program. A contractor has been engaged to install the smoke detector directly above the main fire alarm panel in Room F618. 2. Smoke detectors are present in the affected room F618. A detector is currently located 12 feet from the main fire alarm panel. 3. The affected area is not normally accessed by residents, and is separated by fire rated construction from areas normally accessed by residents.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title Fire Safety Supervisor	Office State Fire Marshal	Date 9-15-14

Name of Facility **2000 CODE**

Benedictine Living Community of St. Peter, 245501, St. Peter, MN

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K 056 A temporary waiver is requested for an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility.	A temporary waiver for K056 is being requested until 12-31-14. A. A temporary waiver for K056 is needed because: 1. Sprinklers installed in two air handling Mechanical Rooms were not installed below ducts. A contractor has been engaged to make the necessary adjustments. 2. The nursing home is fully sprinkled. 3. The affected area is not normally accessed by residents and is separated by fire rated construction from areas normally accessed by residents.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title Fire Safety Supervisor	Office State Fire Marshal	Date 9-15-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	07/31/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	F00 This Plan of Correction is being submitted pursuant to the applicable Federal and State Regulations. Nothing contained herein shall be construed as an admission that the Facility violated any Federal or States Regulations or failed to follow any applicable Standard of Care.	
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of	F 164	F164 Personal Privacy/ Confidentiality of Records 1. Nurses involved were informed of the findings and provided education regarding the proper procedure for use of med station and provision of e-MAR privacy. 2. The nurses will be informed of the survey findings at the nurses meeting held on 9/10/2014. Nurses will be instructed of the need to provide privacy for all residents and the use of the "walk away" button on the e-MAR as well as the policy regarding the use of the Schedule II Medication Record.	9/6/14 GPN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator /CEO — (X6) DATE: 9/4/2014

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.

RECEIVED
SEP 05 2014
Minnesota Department of Health
Marshall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 164	Continued From page 1 the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the confidentiality of medical information located in the electronic medical record for 4 of 4 residents (R39, R57 R84 & R103) who were observed during the medication pass was maintained. Findings include: During observation of the medication pass at nursing station #1 located on Angel wing on 7/29/14, at 7:30 p.m. licensed practical nurse (LPN)-A was observed to set up medications for R84 and then walked away from the station. The computer screen was left open and displayed R84's personal and medical information. This computer screen located on the nursing station was visible to residents, staff and/or visitors who were located in and/or around the dining area. The information displayed on the computer screen included a photo of R84, diagnoses, medications with rationale for prescription and additional personal information. This information remained visible until LPN-A returned to the station, 5 minutes later, after the administration of the medication. The screen remained open the entire time. During continued observation of medication pass on 7/29/14, at 7:32 p.m. LPN-A was observed to open the computer screen to display R39's	F 164	3. A review of the policies regarding the "walk away" button on the e-MAR screen and privacy regarding narcotic book use will be reviewed with the nurses at the nursing meeting on 9/10/2014. 4. Nurse Managers will conduct daily audits for 30 days, then weekly audits for a month, with continued monthly audits. On the spot education will be provided as necessary. The policy and survey results were reviewed at the Quality Council meeting on 8/28/2014. Ongoing audit results will be shared at Quality Council. 5. The DON and Nurse Managers are responsible for compliance. Initiated by ~~September 11, 2014~~.	9/9/14 GPN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 164	Continued From page 2 medical information; set up resident medications and left the area without closing the computer screen. LPN-A searched for R39 until 7:39 p.m. and upon location of R39, administered the medications. LPN-A then returned to the nursing station at 7:42 p.m. Various staff, residents and visitors were observed passing through the area where the computer screen displayed R39's medical information. At 7:45 p.m. LPN-A continued to display the medical information of R39's on the computer screen while she stepped aside, obtained the narcotic book and prepared the narcotic pain patch for R39. LPN-A then documented the medications she had administered and closed the computer screen. Personal medical information was visible and unmonitored for a total of 13 minutes. During observation of the medication pass on 7/30/14; at 8:22 a.m. registered nurse (RN)-B was observed passing medications from nursing station #1. RN-B opened the computer screen displaying R103's photo, medications with reason for administration and diagnoses. RN-B prepared the medications, walked away from the station and left the computer screen open which displayed the personal information. RN-B transported R103 from the dining area into her room, checked her blood glucose level at 8:25 a.m. and then returned to the dining area at 8:27 a.m. The computer screen remained opened with the medical information displayed until 8:39 a.m. when RN-B closed the information on the computer screen. Medical information was visible to anyone in the area of nursing station for 17 minutes. The information could be easily visualized by other residents, visitors and/or staff who were present.	F 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 164	Continued From page 3 During observation of the medication pass on 7/31/14, at 7:45 a.m. LPN-B was located on nursing station #2 located on the Angel wing. LPN-B opened the computer screen to display R57's personal medical information. LPN-B then prepared R57's insulin, walked away from the nursing station to transport R57 into his room where the insulin was administered. The computer screen was viewable to anyone passing through or seated in the dining area. During this time frame, two residents, one dietary staff and one housekeeping personnel were present in the dining area. All of these individuals were noted to walk past the nursing station where the computer screen was left unattended and open to view. The computer terminal was viewable and unattended for 5 minutes while LPN-B left the area of the nursing station. It was noted during observations of the nursing station during the time period of 7/28/14, 7/29, 7/30 and 7/31/14 that narcotic records remained on the counter at the nursing stations. The record book was accessible for review and the public could have access to information related to controlled substances and the amount/types of narcotics stored at the nurses station. During an interview on 7/31/14, at 9:23 a.m. the director of nursing (DON) verified the expectations had been to maintain confidentiality of resident information located in the electronic medical record . The DON indicated that resident personal information was to be protected by clicking the "walk away" button on the computer when staff left the nursing station to administer resident medications. The DON verified the purpose of this button was to protect personal and medical information when staff were not in	F 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 164	Continued From page 4 attendance. The DON further verified the computer screen should be closed and that it was inappropriate for staff to leave the screen open so that it could be viewed by persons who were in the area and/or around the nursing stations and/or dining areas. During this interview the DON also verified that narcotic records were to be stored in the cabinet at the individual nursing stations to protect the private information of the residents who received controlled medications and not on the counter where the contents were accessible for review. Review of the policy for Medication and Treatment Orders/Administration with an effective date of 3/2011 and a review date of 6/2014 was completed related to the use of electronic records. Under the heading of Policy: Included under the sixth section of the policy is stated: "eMAR walk away button is utilized when the facility is not manned". No additional information was provided related to use of the electronic medical record. Review of the Policy RE: Narcotics Effective 1/2008 and revised 7/14 lists under Schedule II Medication: All Schedule II Medications are kept double locked. Narcotic Books should be kept in a locked med drawer or the double locked cabinet.	F 164		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	07/31/2014

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F 431	Continued From page 5 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to dispose of expired as needed (PRN) medications for 3 of 66 residents (R9, R71 & R84) who had medications stored in the medication rooms and the failure to monitor the expiration date for PRN and stock medications listed on the resident standing orders	F 431	F431 Drug Records, Label/Store Drugs & Biologicals 1. Expired medication was immediately removed from the medication storage cabinets. 2. Residents have the potential to be affected by expired medications. To ensure resident safety, nurses will monitor dates on medications. 3. . A review of the policies regarding expiration of medications and removal of those medications was reviewed with the nurses on 8/28/2014. 4. Primary day nurses will conduct weekly audits and a monthly audit of each neighborhood will be completed by a staff nurse. On the spot education will be provided as needed. The policy and survey results were reviewed at the Quality Council meeting on 8/28/2014. Ongoing audit results will be shared at Quality Council. 5. The Director of Nursing and Nurse Managers are responsible for compliance. Initiated by ~~September 11, 2014.~~	9/9/14 GPN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	07/31/2014

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F 431	Continued From page 6 document had the potential to affect 66 residents who reside in the facility. Findings include: Observations of the medication storage areas were conducted on 7/30/14, at 8:30 a.m. and included two (2) medication rooms located on the Angel/Butterfly and Eagle/Dove resident wings and eight nursing stations. R84 had a PRN (as needed) order for Ondansetron (Zofran-anti-nausea) 4 milligram (mg) Tablets 1 PO (per order) q (every) eight (8) h (hours). The expiration date was noted as 3/14 and this medication was last administered on 6/21/14, and verified by registered nurse (RN)-B. R84 had a PRN order for Loperamide (Imodium or Kaopectate) 2 mg by mouth PO q4 hours and the medication had an expiration date of March 2014. This medication was last administered on 6/21/14, and verified by RN-B. During review of the medication storage room located on the Eagle/Dove wing on 7/30/14, at 9:23 a.m. the following was noted: two (2) boxes of Loperamide Hydrochloride 2 mg tablets being used as a stock supply and were located in the stock medication area. The expiration dates were listed as May 2014. This medication was available for PRN use for residents who have physician approved standing orders. This information was verified by licensed practical nurse (LPN)-D. R9 had a PRN order for Loperamide 2 mg PO 1 capsule tid (three times daily). The expiration date was listed as August 2013. LPN-D was	F 431		

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	245501	A. BUILDING _____ B. WING _____	07/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 7 unable to determine when this medication was last administered, but 8 doses were noted missing from the card. This was verified by LPN-D. The medication, Tussin (cough suppressant) one (1) bottle was located in bottom drawer on Dove station #1 with the expiration date of June 2014. LPN-D verified the expiration date, but was unable to determine when last dose had been administered. Tylenol (analgesic) suppositories 650 mg had an expiration date of October 2013. LPN-D was unable to verify when the most recent dose had been administered. R71 had a PRN order for Prochlorperazine (Compazine) 10 mg PO with expiration date of October 2013. LPN-D was unable to verify when last administered. During review of Eagle nursing station #2 on 7/30/14, at 9:40 a.m., one box containing 11 Dulcolax suppositories which was available and ready for use and it was noted to have various expiration dates between July 2013 and July 2014. A card of Loperamide Hydrochloride 2 mg capsules, which was available and ready for use, had an expiration date of May 2014 and noted to have 6 doses missing from the card. LPN-C verified the expiration dates but was unable to verify when the above medications had last been administered. LPN-C and LPN-D were interviewed on 7/30/14, at 9:23 a.m. and verified that medications were routinely stored in the two main medication storage rooms and also on the nursing stations for PRN use. LPN-C& LPN-D further verified the identified medications for R9, R71 and R84 were	F 431		

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F 431	Continued From page 8 past the printed expiration date and should have been removed from the medication storage areas when the weekly medication checks were to be completed. During an interview on 7/30/14, at 9:45 a.m. the director of nursing (DON) verified that nursing staff were to check medications for outdates each time they were on duty and passing medications. She also stated that whenever a medication was found to be outdated the nursing staff person was to remove the medication from the drawer or storage area and place into a drawer labeled for disposal. Review of the policy titled Medication Storage, dated 1/2013 and revised 4/14 identified the following procedure: #6. Drugs shall not be kept on hand after the expiration date on the label and no contaminated or deteriorated drugs shall be available. On a weekly basis the night nurse will check both the refrigerator and drawers for expired medications, remove them and dispose per disposal policy. #11. All medications on hand for residents who expire and those medications not sent home with residents at time of discharge shall be immediately withdrawn from stock and either locked away separately or immediately destroyed in conformance with the drug destruction procedure. #14. Medications procurable without prescription may be retained in stock supply in a separate drawer. These shall have a manufacture date on the label and a date when opened to prevent the accumulation of outdated or deteriorated items.	F 431		

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

F5501022

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FORM APPROVED
OMB NO. 0938-0391

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	245501	A. BUILDING 02 - NEW BUILDING B. WING _____	07/29/2014

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 13, 2013. At the time of this survey, Benedictine Living Community of St. Peter was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145 Facsimile: 651-215-0525, or	K 000	F00 This Plan of Correction is being submitted pursuant to the applicable Federal and State Regulations. Nothing contained herein shall be construed as an admission that the Facility violated any Federal or States Regulations or failed to follow any applicable Standard of Care. POC ok w/TW's for K52 + K56 PS 9-15-14 RECEIVED SEP 10 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dc:

EXIT:

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

Administrator, CEO 9/9/2014

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

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K 000	Continued From page 1 By e-mail 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. Benedictine Living Community of St. Peter was constructed in 2006 at two different times. The original building is a one story building with no basement of Type V(111) construction. The addition constructed in 2006, with a link to the hospital is a one story building with no basement of Type V(111) construction. The building is fully fire sprinkler protected. The nursing home is separated from a hospital and a senior housing facility by 2-hour fire wall assemblies, with opening protectives consisting of labeled, self-closing, positive latching, 90-minute fire rated door assemblies. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility also has automatic smoke detection in all sleeping rooms. Because the original building and the addition meet the construction type allowed for new buildings, the 2 buildings will be surveyed as one building. The facility has a capacity of 79 beds	K 000		

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K 000	Continued From page 2 and had a census of 74 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has failed to maintain the 2-hour fire separation at the 2 required locations. This deficient practice could affect the safety of all residents, staff and visitors in the event of a fire, as fire and smoke could pass from one building to the other. Findings include: On facility tour between 9:30 AM and 3:00 PM on 07-29-2014, it was observed that the 2-hour fire separation doors did not operate as required in the following locations: 1) The fire barrier door between the nursing home and the hospital did not self close and latch when tested. 2) The fire barrier doors between building B and Building C did not self close and latch when tested.	K 011	K011 NFPA 101 Life Safety Code Standard 1. Adjustments are being made to the fire barrier doors at the connection with the hospital and between buildings B and C to self-close and latch. 2. The proposed completion date is by September 9, 2014. 3. The Environmental Services Director is responsible for assuring the latching and closure of the fire barrier doors.	

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K 011	Continued From page 3 These deficiencies were verified by Environmental Service Director (DB) at the time of discovery.	K 011		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility did not have corridor doors that meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. This deficient practice could affect the safety of the residents within the smoke compartment. Findings include: On facility tour between 9:30 AM and 3:00 PM on 07-29-2014, it was observed that the corridor doors did not latch into the frame at the following locations: 1) Staff Break Room door to the corridor F615 did not have a latch on the door. 2) Linen room door to the corridor B226 did not latch when tested. This deficiency was verified by Environmental Service Director (DB) at the time of discovery.	K 018	K018 NFPA 101 Life Safety Code Standard 1. A latch is being installed on the break room door. The completion date is September 24, 2014. 2. The linen door B226 was adjusted to assure the latch closed when tested. The completion date is September 5, 2014. 3. The Environmental Services Director is responsible for assuring the work is completed and doors latch as required.	
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a	K 027		

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K 027	Continued From page 4 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barrier doors as required by NFPA 101 -2000 edition, Sections 19.3.7.6, 8.3.4, 8.3.4.1, 8.3.4.2 and 8.3.4.3. This deficient practice could all residents in 2 smoke compartments. Findings include: On facility tour between 9:30 AM and 3:00 PM on 07-29-2014, it was observed that there was a 1/2 inch gap at the meeting edge of the cross-corridor smoke barrier doors by room A136. The doors did not have an astragal to cover the gap. This deficiency was verified by Environmental	K 027	K027 NFPA 101 Life Safety Code Standard 1. An astragal has been ordered and will be installed on the smoke barrier doors by room A136. 2. The completion date is September 24, 2014. 3. The Environmental Services Director is responsible for assuring the work is completed.	

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K 027	Continued From page 5 Service Director (DB) at the time of discovery.	K 027		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 18.3.6.2. This deficient practice could affect staff patients and visitors within the smoke compartment. Findings include: On facility tour between 9:30 AM and 3:00 PM on 07-29-2014, it was observed that: 1) Soiled Utility room door to the corridor D418 did not self close and latch when tested. 2) Storage Room door to the corridor F610 was held open with a magnet which does not release with the Fire alarm. 3) Corridor door to the Kitchen By room F604 did not self close and latch when tested. These deficiencies were verified by Environmental Service Director (DB) at the time of discovery.	K 029	K029 NFPA 101 Life Safety Code Standard 1. The soiled utility room door D418 and corridor door to the kitchen room F604 were adjusted to assure the self-closure was operational and the door latched. The magnet holding the storage room door F610 was removed. 2. The completion date is August 28, 2014. 3. The Environmental Services Director is responsible for assuring the work is completed and doors latch as required.	
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware	K 050		

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K 050	Continued From page 6 that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview,, it was determined that the facility failed to conduct fire drills in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Findings include: On facility tour between 9:30 AM and 3:00 PM on 07-29-2014, based on review of available documentation it was reveled that fire drills were not varied throughout the evening and night shifts: Drills are conducted one per shift per quarter however, during the evening shift 3 of 4 drills are conducted between the 2:30 PM 3:10 PM time period. During the night shift 3 of 4 drills are conducted during the 2:00 AM to 3:00 AM time period. This deficiency was verified by Environmental Service Director (DB) at the time of discovery.	K 050	K050 NFPA 101 Life Safety Code Standard 1. The fire drill schedule was reworked to assure drills are rotated throughout a shift and not overlapping. 2. The completion date is August 28, 2014. 3. The Environmental Services Director is responsible for assuring fire drills rotate throughout a 24 hour period.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable	K 052		

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K 052	Continued From page 7 requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on review and interview, the facility has failed to properly maintain the fire alarm system in accordance with NFPA 72, 1999 Edition. Section 9.6.1.4. This deficient practice could affect all occupants including residents, staff and visitors. Findings include: On facility tour between 9:30 AM and 3:00 PM on 07-29-2014, It was revealed during review of available fire alarm documentation that: 1) The fire alarm system tests and inspection was not conducted on an annual basis. The testing from 10-18-12 to testing of 11-20-13 was more than 12 months. 2) Mechanical Room F618, did not have a smoke detector directly above the main fire alarm panel. This deficiency was verified by Environmental Service Director (DB) at the time of discovery.	K 052	K052 NFPA 101 Life Safety Code Standard 1. Fire alarm system tests and inspections will be conducted on an annual basis and completed within a 12 month period. The completion date was July 31, 2014. 2. A request for a temporary waiver for K052 is being made until 12/31/2014 to install a smoke detector directly above the main fire alarm panel in Room F618. 3. The Environmental Services Director is responsible for assuring the inspections are held on an annual basis.	12/31/14
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped	K 056		

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K 056	Continued From page 8 with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. This STANDARD is not met as evidenced by: Based on observation and interview it was revealed that the automatic fire sprinkler system is not in installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). This deficient practice could negatively impact all the residents, visitors and staff. Findings include: On facility tour between 9:30 AM and 3:00 PM on 07-29-2014, it was observed that: Sprinkler heads were obstructed in the two air handling Mechanical Rooms. Sprinkler heads were above ducts but not below. Ducts were 52 inches in width. These deficiencies were verified by Environmental Service Director (DB) at the time of discovery.	K 056	K056 NFPA 101 Life Safety Code Standard 1. A request for a temporary waiver for K056 is being made until 12/31/2014 to install sprinkler heads in the air handling mechanical rooms to meet the requirements of NFPA 13. 2. The Environmental Services Director is responsible for assuring the work is completed.	12/31/14
K 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than	K 076		

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K 076	Continued From page 9 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview,medical gas was not stored in accordance with NFPA 99, Standards for Healthcare Facilities. This deficient practice could negatively impact all residents, visitors and staff within the smoke compartment. Findings include: On facility tour between 9:30 AM and 3:00 PM on 07-29-2014, it was observed that: The Oxygen Storage room B236 had an oxygen bottle not secured in its holder. This deficiency was verified by Environmental Service Director (DB) at the time of discovery.	K 076	K076 NFPA 101 Life Safety Code Standard 1. Oxygen bottles will be secured in a holder. 2. The completion date was 7/29/2014. 3. The Nurse Managers will be responsible to monitor the oxygen storage rooms and assure that the oxygen bottles are secured in holders.	
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2	K 143		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING 02 - NEW BUILDING B. WING _____	07/29/2014

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

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K 143	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation, the facility transfer/oxygen storage room a non-compliant room with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This deficient practice could affect the safety of all residents, staff and visitors within the smoke compartment. Findings include: On facility tour between 9:30 AM and 3:00 PM on 07-29-2014, it was observed that the Oxygen transfer/storage room door to the corridor D433 did not self close and latch when tested. This deficiency was verified by Environmental Service Director (DB) at the time of discovery.	K 143	K0143 NFPA 101 Life Safety Code Standard 1. The oxygen storage room door D433 was adjusted to assure the door latched. 2. The completion date is August 28, 2014. 3. The Environmental Services Director is responsible for assuring the door latches as required.	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has failed to ensure that extension cords are not being used as a substitute for permanent wiring. This deficient practice could affect the safety of all residents, visitors and staff. Findings include: On facility tour between 9:30 AM and 3:00 PM on 07-29-2014, it was observed that: 1) Main Laundry Room had an extension cord connected to the washing machine.	K 147	K0147 NFPA 101 Life Safety Code Standard 1. The extension cord was removed from the laundry room and the power strips were removed from usage with therapy equipment and in mechanical shop. 2. The completion date is August 28, 2014. 3. The Environmental Services Director is responsible for assuring that no extension cords are utilized in the facility.	

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K 147	Continued From page 11 2) Therapy Room had an extension cord connected to an exercise machine. 3) Mechanical Shop by by Environmental Directors office had a power strip plugged into a Microwave and multi plug adapter plugged in used for charging batteries. This deficiency was verified by Environmental Service Director (DB) at the time of discovery.	K 147		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3055 0578

August 25, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5501024

Dear Ms. Spike:

The above facility was surveyed on July 28, 2014 through July 31, 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 this office at:

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, MN 56258
Kathryn.serie@state.mn.us
Office: (507) 537-7158
Fax: (507) 537-7194

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 me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00399	A. BUILDING: _____ B. WING _____	07/31/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On 7/21, 7/22, 7/23 and 7/24/14, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of	2 000	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.	

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2 000	Continued From page 1 these orders for your records and return the original to the address below: Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program, 1400 E. Lyon Street, Marshall, MN 56258 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000	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 which 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.	
21860	MN St. Statute 144.651 Subd. 16 Patients & Residents of HC Fac.Bill of Rights Subd. 16. Confidentiality of records. Patients and residents shall be assured confidential	21860		

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21860	Continued From page 2 treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview. Copies of records and written information from the records shall be made available in accordance with this subdivision and section 144.335. This right does not apply to complaint investigations and inspections by the Department of Health, where required by third party payment contracts, or where otherwise provided by law. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the confidentiality of medical information located in the electronic medical record for 4 of 4 residents (R39, R57 R84 & R103) who were observed during the medication pass was maintained. Findings include: During observation of the medication pass at nursing station #1 located on Angel wing on 7/29/14, at 7:30 p.m. licensed practical nurse (LPN)-A was observed to set up medications for R84 and then walked away from the station. The computer screen was left open and displayed R84's personal and medical information. This computer screen located on the nursing station was visible to residents, staff and/or visitors who were located in and/or around the dining area.	21860		

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21860	Continued From page 3	21860		

The information displayed on the computer screen included a photo of R84, diagnoses, medications with rationale for prescription and additional personal information. This information remained visible until LPN-A returned to the station, 5 minutes later, after the administration of the medication. The screen remained open the entire time.

During continued observation of medication pass on 7/29/14, at 7:32 p.m. LPN-A was observed to open the computer screen to display R39's medical information; set up resident medications and left the area without closing the computer screen. LPN-A searched for R39 until 7:39 p.m. and upon location of R39, administered the medications. LPN-A then returned to the nursing station at 7:42 p.m. Various staff, residents and visitors were observed passing through the area where the computer screen displayed R39's medical information. At 7:45 p.m. LPN-A continued to display the medical information of R39's on the computer screen while she stepped aside, obtained the narcotic book and prepared the narcotic pain patch for R39. LPN-A then documented the medications she had administered and closed the computer screen. Personal medical information was visible and unmonitored for a total of 13 minutes.

During observation of the medication pass on 7/30/14, at 8:22 a.m. registered nurse (RN)-B was observed passing medications from nursing station #1. RN-B opened the computer screen displaying R103's photo, medications with reason for administration and diagnoses. RN-B prepared the medications, walked away from the station and left the computer screen open which displayed the personal information. RN-B transported R103 from the dining area into her

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21860	Continued From page 4 room, checked her blood glucose level at 8:25 a.m. and then returned to the dining area at 8:27 a.m. The computer screen remained opened with the medical information displayed until 8:39 a.m. when RN-B closed the information on the computer screen. Medical information was visible to anyone in the area of nursing station for 17 minutes. The information could be easily visualized by other residents, visitors and/or staff who were present. During observation of the medication pass on 7/31/14, at 7:45 a.m. LPN-B was located on nursing station #2 located on the Angel wing. LPN-B opened the computer screen to display R57's personal medical information. LPN-B then prepared R57's insulin, walked away from the nursing station to transport R57 into his room where the insulin was administered. The computer screen was viewable to anyone passing through or seated in the dining area. During this time frame, two residents, one dietary staff and one housekeeping personnel were present in the dining area. All of these individuals were noted to walk past the nursing station where the computer screen was left unattended and open to view. The computer terminal was viewable and unattended for 5 minutes while LPN-B left the area of the nursing station. It was noted during observations of the nursing station during the time period of 7/28/14, 7/29, 7/30 and 7/31/14 that narcotic records remained on the counter at the nursing stations. The record book was accessible for review and the public could have access to information related to controlled substances and the amount/types of narcotics stored at the nurses station. During an interview on 7/31/14, at 9:23 a.m. the	21860		

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21860	Continued From page 5	21860		

director of nursing (DON) verified the expectations had been to maintain confidentiality of resident information located in the electronic medical record . The DON indicated that resident personal information was to be protected by clicking the "walk away" button on the computer when staff left the nursing station to administer resident medications. The DON verified the purpose of this button was to protect personal and medical information when staff were not in attendance. The DON further verified the computer screen should be closed and that it was inappropriate for staff to leave the screen open so that it could be viewed by persons who were in the area and/or around the nursing stations and/or dining areas.

During this interview the DON also verified that narcotic records were to be stored in the cabinet at the individual nursing stations to protect the private information of the residents who received controlled medications and not on the counter where the contents were accessible for review.

Review of the policy for Medication and Treatment Orders/Administration with an effective date of 3/2011 and a review date of 6/2014 was completed related to the use of electronic records. Under the heading of Policy: Included under the sixth section of the policy is stated: "eMAR walk away button is utilized when the facility is not manned". No additional information was provided related to use of the electronic medical record.

Review of the Policy RE: Narcotics Effective 1/2008 and revised 7/14 lists under Schedule II Medication: All Schedule II Medications are kept double locked. Narcotic Books should be kept in a locked med drawer or the double locked

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21860	Continued From page 6 cabinet. SUGGESTED METHOD OF CORRECTION: The DON could inservice staff regarding the importance of confidentiality and privacy of resident information displayed on the computer screen while staff were not present in the area and/or not utilizing the computer screen. An periodic audit could be conducted to ensure compliance and the findings could be communicated to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21860		