DEPARTMENT OF HEAL	TH AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICI	ES
	MEDICA	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: K7Z8	
	PART I -	TO BE COMPI	LETED BY 1	THE STAT	TE SURVEY AGENCY	Facility ID: 00399	
1. MEDICARE/MEDICAID PROVID (L1) 245501 2.STATE VENDOR OR MEDICAID (L2) 849623400		 NAME AND AI (L3) BENEDICT (L4) 1907 KLEIN (L5) ST PETER, 	INE LIVING (STREET		NITY (L6) 56082	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint	DN
5. EFFECTIVE DATE CHANGE OF (L9) 10/01/2004	FOWNERSHIP	7. PROVIDER/SU01 Hospital		GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint	
6. DATE OF SURVEY 01/0 8. ACCREDITATION STATUS: 0 Unaccredited 0 Unaccredited 1 TJC 2 AOA 3 Other	02/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L3 12/31	5)
 11LTC PERIOD OF CERTIFICATIO From (a): To (b): 12.Total Facility Beds 	DN 79 (L18)	Complianc		AS:	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	The Following Requirements: 6. Scope of Services Limit 7. Medical Director IF) 8. Patient Room Size 9. Beds/Room	
13.Total Certified Beds	79 (L17)		pliance with Progents and/or Appli		* Code: A*	(L12)	
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF 79	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REAS	MARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:	
Thomas Linhiff, DS	FM	0	1/16/2015	(L19)	Mark Meath,	Enforcement Specialist 07/17/201	5 (L20)
PA	ART II - TO BE	COMPLETED I	BY HCFA RE		COFFICE OR SINGLE S	TATE AGENCY	(120)
 DETERMINATION OF ELIGIB <u>X</u> 1. Facility is Eligible to <u>2</u>. Facility is not Eligible 	ILITY Participate	20. COM	IPLIANCE WITH ITS ACT:		21. 1. Statement of Fina	ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)	
				1			
22. ORIGINAL DATE OF PARTICIPATION 11/01/1987	23. LTC AGREEN BEGINNING		4. LTC AGREEN ENDING DA		26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	
	A. Suspensior	of Admissions:	(L44)		04-Ouler Reason for windrawar	07-Provider Status Change 00-Active	
(L27)	B. Rescind Su	spension Date:					
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
	(L28)	03001		(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE			
	(L32)	10/01/2014		(L33)	DETERMINATION APP	ROVAL	

DETERMINATION APPROVAL

(L32)

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.



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,

Benedictine Living Community January 16, 2015 Page 2

Kamala Piske 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

Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245501	A. Building	° 02 - NEW BUILDING	
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 2/31/2014	ID Prefix		Correction Completed 12/31/2014	ID Prefix		Correction Completed
	NFPA 101			NFPA 101	-	Reg. #		
LSC	K0052		LSC	K0056	-			
	С	Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #			Reg. #			Dec. #		
LSC			LSC		-	LSC		
	C	Correction			Correction			Correction
ID Profix	C	Completed			Completed	ID Profix		Completed
Reg. #			Reg. #		_			
LSC					-	LSC		
	C	Correction			Correction			Correction
ID Dueffer	(Completed	ID Due fin		Completed	ID Due fue		Completed
					_			
Reg. # LSC			Reg. # LSC		-	Reg. # LSC		
		Correction Completed			Correction Completed			Correction Completed
ID Prefix		Jompieted	ID Prefix			ID Prefix		
Reg. # LSC			Reg. #		-	Reg. #		
			200		-			
Reviewed I	By Reviewed I	Зv	Date:	Signature of Su	rvevor:		Date	
State Agen		-	01/16/201	-	-	2424		/02/2015
Reviewed I	By Reviewed I		Date:	Signature of Su			Date	
CMS RO								
Followup t	o Survey Completed on: 7/29/2014			Check for any Unco Uncorrected Defi				5 NO
	1/20/2014				•	-	· 163	

DEPARTMENT OF HEAL			D CERTIFIC	CATION	CENTERS FOR MEI AND TRANSMITTAL	DICARE & MEDICAID SERVICES ID: K7Z8
	PART I -	TO BE COMPI	LETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00399
1. MEDICARE/MEDICAID PROVI (L1) 245501 2.STATE VENDOR OR MEDICAID (L2) 849623400		 NAME AND ADDRESS OF FACILITY (L3) BENEDICTINE LIVING COMMUN (L4) 1907 KLEIN STREET (L5) ST PETER, MN 			NITY (L6) 56082	4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
 EFFECTIVE DATE CHANGE OF (L9) 10/01/2004 DATE OF SURVEY 09/ ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 	15/2014 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEG 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	60RY 09 ESRD 10 NF 11 ICF/III 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF D 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 12/31
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 	DN 79 (L18)	Complianc 1. A	nce With equirements te Based On: cceptable POC		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director
13.Total Certified Beds	79 (L17)	B. Not in Con Requireme	npliance with Prog ents and/or Appli	gram ed Waivers:	* Code: A	(L12)
14. LTC CERTIFIED BED BREAKE	OWN	1			15. FACILITY MEETS	
18 SNF 18/19 SNI 79	5 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY RE Documentation supporting				,	and K56 with a complet	ion date of 12/31/2014, has been
approved. 17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Gary Nederhoff, Unit	Supervisor	1	0/01/2014	(L19)	Kamala Fiske-Downing	Enforcement Specialist ^{10/10/2014} (L20)
P	ART II - TO BE	COMPLETED I	BY HCFA RE	EGIONA	L OFFICE OR SINGLE S	STATE AGENCY
 DETERMINATION OF ELIGIB 1. Facility is Eligible to 2. Facility is not Eligible 	Participate		IPLIANCE WITH HTS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	/IENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION 11/01/1987	BEGINNINC		ENDING DA		VOLUNTARY 00 01-Merger, Closure	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	
25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS A. Suspension of Admissions:					03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER
(L27)	B. Rescind Su	spension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
	(L28)	03001		(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION 10/01/2014	OF APPROVAL	L DATE		
	(L32)	10/01/2017		(L33)	DETERMINATION APP	ROVAL



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.

Benedictine Living Community October 10, 2014 Page 2

Please contact me if you have 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: Licensing and Certification File



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.

Benedictine Living Community September 30, 2014 Page 2 Feel free to contact me if you have questions.

Sincerely,

Kumala 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

Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245501	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/15/2014
Nam	e of Facility		Street Address, City, State, Zip Code	
BE	NEDICTINE 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	i) Date	(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date
ID Prefix Reg. #	483.10(e), 483.75(l)(4)	Correction Completed _09/09/2014	ID Prefix Reg. #	483.60(b), (d), (e)	Correction Completed 09/09/2014			
LSC		-	LSC			LSC		_
ID Prefix Reg. # LSC					Correction Completed	D "		
ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #		Correction Completed	ID Prefix		Correction Completed
ID Prefix Reg. # LSC		Correction Completed						Correction Completed
Reg. #			Reg. #					
Reviewed I		-	Date:	_	of Surveyor:		Date	
State Agen Reviewed I CMS RO	cy <u>GP1</u> By Reviewed	N/KFD d By	10/01/20 Date:		1(of Surveyor:)160	Date	09/15/2014
Followup t	o Survey Completed o 7/31/2014	n:			Jncorrected Defic Deficiencies (CM			NO

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245501	(Y2) Multiple Cons A. Building B. Wing			(Y3) Date of Revisit 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
		Correction			Correction					Correction
ID Prefix		Completed 09/09/2014	ID Prefix		Completed 09/05/2014		ID Prefix			Completed 09/24/2014
0	NFPA 101		0	NFPA 101			0	NFPA 101		
LSC	K0011		LSC	K0018			LSC	K0027		
		Correction			Correction					Correction
ID Prefix		Completed 08/28/2014	ID Prefix		Completed 08/28/2014		ID Prefix			Completed 07/29/2014
Reg. #	NFPA 101		Reg. #	NFPA 101				NFPA 101		
	K0029			K0050				K0076		
		Correction			Correction					Correction
ID Drofiv		Completed	ID Drofiv		Completed		ID Brofiv			Completed
ID Prefix		08/28/2014			08/28/2014					
	NFPA 101 K0143			NFPA 101 K0147			Reg. # LSC			
		Correction			Correction					Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			Completed
Reg. #			Reg. #				Reg. #			
LSC			LSC				LSC			
		Correction			Correction					Correction
ID Profix		Completed	ID Brofiv		Completed	Completed	ID Profix			Completed
Reg. #							– "			
			Reg. # LSC				Reg. # LSC			
Reviewed E	Зу В	eviewed By	Date:	Signature	e of Surveyor:				Date:	
State Agen	cy (GPN/KFD	09/30/20	14	3	2978				09/29/2014
Reviewed E CMS RO	3y R	eviewed By	Date:	Signature	e of Surveyor:				Date:	
Followup t	o Survey Comp 7/29/2				y Uncorrected Def ed Deficiencies (C					NO

DEPARTMENT OF HEALTI	HAND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: K7Z8
	PART I -	TO BE COMPI	LETED BY 1	THE STA	TE SURVEY AGENCY	Facility ID: 00399
1. MEDICARE/MEDICAID PROVIDE (L1) 245501	R NO.	3. NAME AND AD (L3) BENEDICT			NITV	4. TYPE OF ACTION: <u>2</u> (L8)
(L1) 245501 2.STATE VENDOR OR MEDICAID N	0	(L4) 1907 KLEIN		comme		1. Initial 2. Recertification
(L2) 849623400	0.	(L5) ST PETER, MN			(L6) 56082	3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF C	OWNERSHIP	7. PROVIDER/SUPPLIER CATEGORY			<u>02</u> (L7)	7. On-Site Visit 9. Other 8. Full Survey After Complaint
(L9) 10/01/2004	014	01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	
 6. DATE OF SURVEY 07/31/2 8. ACCREDITATION STATUS: 	2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/III	14 CORF D 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC	(L10)	04 SNF	07 A-Kay 08 OPT/SP	12 RHC	16 HOSPICE	12/31
2 AOA 3 Other						
11. LTC PERIOD OF CERTIFICATION	I	10.THE FACILITY		AS:		
From (a):		A. In Complian			And/Or Approved Waivers Of 2. Technical Personnel	The Following Requirements:
To (b):			equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds	79 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code	
13.Total Certified Beds	79 (L17)	X B. Not in Com Requireme	ppliance with Pro ents and/or Appl			(L12)
14. LTC CERTIFIED BED BREAKDO	WN	1			15. FACILITY MEETS	
18 SNF 18/19 SNF 79	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM.	ARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
<u>Pamela Manzke, HFE NE I</u>	I	0	9/15/2014	(L19)	Kamala Fiske-Downing,	Enforcement Specialist 09/30/2014 (L20)
PAI	RT II - TO BE	COMPLETED H	BY HCFA RI	EGIONA	L OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGIBIL	ITY		IPLIANCE WIT	H CIVIL		ncial Solvency (HCFA-2572)
1. Facility is Eligible to P	articipate	RIGE	ITS ACT:		2. Ownership/Contro 3. Both of the Above	bl Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	(L21)					
	(121)					
22. ORIGINAL DATE	23. LTC AGREE		4. LTC AGREEN		26. TERMINATION ACTION:	
OF PARTICIPATION 11/01/1987	BEGINNINC	G DATE	ENDING DA	TE	<u>VOLUNTARY</u> <u>00</u>	
	7 (1)		(J. 0.5)		01-Merger, Closure 02-Dissatisfaction W/ Reimburse	05-Fail to Meet Health/Safety ement 06-Fail to Meet Agreement
(L24)	(L41) 27. ALTERNATI		(L25)		03-Risk of Involuntary Terminatio	nn
25. LTC EXTENSION DATE:		n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
	1		(L44)			00-Active
(L27)	B. Rescind St	uspension Date:				
			(L45)			
28. TERMINATION DATE:	29	0. INTERMEDIARY/	CAKRIER NO.		30. REMARKS	
	(L28)	03001		(L31)		
	(120)			(LJ1)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAI	LDATE		
	(L32)			(L33)	DETERMINATION APPI	ROVAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: K728 PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00399

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.



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor Minnesota Department of Health 1400 E. Lyon Street Marshall, MN 56258 <u>Kathryn.serie@state.mn.us</u> 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.

Benedictine Living Community August 25, 2014 Page 4

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 Benedictine Living Community August 25, 2014 Page 5 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

Benedictine Living Community August 25, 2014 Page 6

Feel free to contact me if you have questions.

Sincerely,

Kumalu 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

Enclosure

cc: Licensing and Certification File

Sheehan, Pat (DPS)

From:	Sheehan, Pat (DPS)
Sent:	Monday, September 15, 2014 9:31 AM
То:	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 D52	A temporary w	vaiver for K	(052 is being req	uested until 12-31-14.		
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	 The orig additional smo smoke detecto Smoke of main fire alarr The affe 	inal contra oke detecto or directly a detectors a n panel. acted area i	or will require cor above the main fi are present in the is not normally a	in business and the prog nection to the program. ire alarm panel in Room affected room F618. A o	A contractor has F618. detector is currer	ed out. To install an s been engaged to install ntly located 12 feet from t y fire rated construction f
Electrical Code and NFPA 72.	areas normali	y accessed	d by residents.			5 8 0
	2					2
~				×	14	522 131
34 17 141	1				¥	× .
	58 12	а.	, .			
Surveyor (Signature)	1	Title	¥ 13	Office		Date
Fire Authority Official (Signatu	ıre)	Fitle	Fire Safety	Office State Fire		Date 9-15-14

Name of Facility

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

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

2000 CODE

2

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)			h	JUSTIFICATION	1
к 056	A temporary	waiver for	K056 is being red	quested until 12-31-14.	
A temporary waiver is requested for an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems,	1. Sprinkl has been en 2. The nu 3. The aff	lers installe gaged to n irsing home fected area	nake the necessa e is fully sprinkled	ling Mechanical Rooms were n ry adjustments. I.	ot installed below ducts. A contractor eparated by fire rated construction from
with approved components, devices, and equipment, to provide complete coverage of all portions of the facility.		е у ^{со}	¥ 10 10	та 1931 — И. 24	>>
л. — н. ж		5			
11 6 <u>4</u> 2	i) te	9. 9		ž	ê a
5. B	-	•	. <u>3</u> .	и 12 -	а 1
Surveyor (Signature)		Title		Office	Date
Fire Authority Official (Signati	ure)	Title	Fire Safety Supervisor	OfficeState Fire Marshal	Date 9-15-14

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURV COMPLETEI	
		245501	B. WING	· · · · · · · · · · · · · · · · · · ·	07	/31/2014
	PROVIDER OR SUPPLIER	JNITY		STREET ADDRESS, CITY, STATE, ZIF 1907 KLEIN STREET ST PETER, MN 56082		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIÈNCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE	(X5) COMPLETI DATE
F 000	INITIAL COMMENT	S	F 000			
F 164	as your allegation of Department's accep bottom of the first pa be used as verificati Upon receipt of an a revisit of your facility validate that substar regulations has been your verification. 483.10(e), 483.75(l)(acceptable POC an on-site may be conducted to ntial compliance with the n attained in accordance with	F 164	F00 This Plan of Correc submitted pursuant to th Federal and State Regu Nothing contained herei construed as an admissi Facility violated any Fed States Regulations or fai any applicable Standard	e applicable lations. n shall be on that the eral or led to follow	
	confidentiality of his records. Personal privacy incl medical treatment, w communications, per meetings of family ar	rsonal care, visits, and nd resident groups, but this facility to provide a private	9/6/1	F164 Personal Privacy/ Confidentiality of Record 1. Nurses involved wer of the findings and provi education regarding the procedure for use of mer and provision of e-MAR	ds re informed ded proper d station privacy.	
	section, the resident release of personal a individual outside the The resident's right to and clinical records d resident is transferred nstitution; or record r	o refuse release of personal loes not apply when the d to another health care release is required by law.	Ġρŋ	2. The nurses will be inf the survey findings at the meeting held on 9/10/20 will be instructed of the n provide privacy for all res the use of the "walk away the e-MAR as well as the regarding the use of the s Medication Record.	e nurses 14. Nurses eed to idents and / [*] button on policy	
C	contained in the resid	o confidential all information lent's records, regardless of				
Lui	L. c. ch-	VSUPPLIER REPRESENTATIVE'S SIGN		TITLE Administrator	INFO 91	(X6) DATE 4/2014
ving the da	ate of survey whether or n the date these documents	asterisk (*) denotes a deficiency whi ction to the patients. (See instruction ot a plan of correction is provided. F are made available to the facility. If	s.) Except for	nursing homes, the findings stated	above are disclosat	ole 90 days
1 CMS-2567	(02-99) Previous Versions Ob	solete Event ID: K7Z811	Faci	Ility ID: 00399 SFP 0 5 2014	If continuation shee	t Page 1 of

PRINTED: 08/25/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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BENEDI	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 1907 KLEIN STREET ST PETER, MN 56082		
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F 164	the form or storage release is required healthcare institutio contract; or the resi	methods, except when by transfer to another n; law; third party payment	F 16	3. A review of the policies re	egarding	
	review the facility fa confidentiality of me the electronic medic R39, R57 R84 & R1	ion, interview and document iled to ensure the idical information located in cal record for 4 of 4 residents (03) who were observed on pass was maintained.		 the "walk away" button on the MAR screen and privacy regonarcotic book use will be rew with the nurses at the nursin meeting on 9/10/2014. 4. Nurse Managers will considering audits for 30 days, ther audits for a month, with contract of the second sec	e e- jarding riewed g duct weekly	
	nursing station #1 lo 7/29/14, at 7:30 p.m (LPN)-A was observ R84 and then walke computer screen wa	of the medication pass at located on Angel wing on m. licensed practical nurse ved to set up medications for ed away from the station. The vas left open and displayed i medical information. This vested on the station.		monthly audits. On the spot education will be provided as necessary. The policy and s results were reviewed at the Council meeting on 8/28/201 Ongoing audit results will be at Quality Council.	s urvey Quality 4. shared	
- - - - - - - - - - - - - - - - - - -	was visible to reside were located in and/ The information disp screen included a ph medications with rati additional personal in remained visible unti station, 5 minutes lat	nts, staff and/or visitors who or around the dining area. layed on the computer noto of R84, diagnoses, onale for prescription and nformation. This information I LPN-A returned to the ter, after the administration The screen remained open		5. The DON and Nurse Mar are responsible for complian Initiated by September 11, 2	ce.	
	During continued obs on 7/29/14, at 7:32 p	servation of medication pass .m. LPN-A was observed to creen to display R39's	J			

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Minnestoa Department of Health Marshall

PRINTED: 08/25/2014 FORM APPROVED OMB NO. 0938-0391

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE 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 medication pass on 7/30/14, at 8:22 a.m. registered nurse (RN)-B was observed passing medications swith reason for administration and diagnoses. RN-B prepared the medications, walked away from the station and left the computer screen open which displaying R103's photo, medications with reason for administration and diagnoses. RN-B prepared the medication, walked away from the station and then the under open which displayed the personal information. RN-B transported R103 from the dining area at 8:25 a.m. and then returned to the dining area at 8:27 a.m. The computer screen meanined opened with the medical information displayed until 8:39 a.m. when RN-B closed the information for 17 minutes. The information could be easily	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DAT	E SURVEY
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visualized by other residents, visitors and/or staff who were present.	F 164	medical information and left the area wi screen. LPN-A seat and upon location of medications. LPN-A station at 7:42 p.m. visitors were obser- where the compute medical information continued to display R39's on the compu- aside, obtained the the narcotic pain pa- documented the me administered and c Personal medical in unmonitored for a t During observation 7/30/14, at 8:22 a.n was observed pass station #1. RN-B op displaying R103's p for administration a the medications, wa and left the compute displayed the perso transported R103 fr room, checked her a.m. and then retur a.m. The computer the medical informa when RN-B closed computer screen. If visible to anyone in 17 minutes. The infi	r, set up resident medications thout closing the computer reched for R39 until 7:39 p.m. of R39, administered the A then returned to the nursing Various staff, residents and ved passing through the area r screen displayed R39's h. At 7:45 p.m. LPN-A y the medical information of uter screen while she stepped narcotic book and prepared atch for R39. LPN-A then edications she had losed the computer screen. hformation was visible and otal of 13 minutes. of the medication pass on h. registered nurse (RN)-B ing medications from nursing bened the computer screen hoto, medications with reason nd diagnoses. RN-B prepared alked away from the station er screen open which nal information. RN-B rom the dining area into her blood glucose level at 8:25 ned to the dining area at 8:27 screen remained opened with ation displayed until 8:39 a.m. the information on the Vedical information was the area of nursing station for ormation could be easily	F 164			

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Manestoa Department of Health Marchall

PRINTED: 08/25/2014
FORM APPROVED
OND NO 0020 0204

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING				/31/2014	
NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY				190	REET ADDRESS, CITY, STATE, ZIP CC 7 Klein Street Peter, MN 56082	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 164	7/31/14, at 7:45 a.n nursing station #2 l LPN-B opened the R57's personal mee prepared R57's insi- nursing station to tr where the insulin w computer screen w through or seated in time frame, two res- one housekeeping dining area. All of t walk past the nursin screen was left unal computer terminal w	ge 3 of the medication pass on h. LPN-B was located on ocated on the Angel wing. computer screen to display dical information. LPN-B then ulin, walked away from the ansport R57 into his room as administered. The as viewable to anyone passing in the dining area. During this idents, one dietary staff and personnel were present in the hese individuals were noted to ng station where the computer ttended and open to view. The was viewable and unattended LPN-B left the area of the	F	164			
	station during the til 7/30 and 7/31/14 th on the counter at th book was accessibl could have access controlled substance narcotics stored at in During an interview director of nursing (expectations had be of resident informate medical record. Th personal informatio clicking the "walk as when staff left the n resident medication purpose of this butt	on 7/31/14, at 9:23 a.m. the					

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

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		& MEDICAID SERVICES			<u> </u>	ND NO.	0930-0381
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245501	B. WING			07/31/2014	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	CTINE LIVING COMM	UNITY			1907 KLEIN STREET ST PETER, MN 56082		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PRÉFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE ·	(X5) COMPLETION DATE
F 164 -	attendance. The D computer screen sl inappropriate for sta that it could be view	ON further verified the nould be closed and that it was aff to leave the screen open so yed by persons who were in und the nursing stations	۲ -	164			
	narcotic records we at the individual nu private information controlled medicati	w the DON also verified that are to be stored in the cabinet sing stations to protect the of the residents who received ons and not on the counter were accessible for review.					
	Treatment Orders// date of 3/2011 and completed related t records. Under the under the sixth sec "eMAR walk away facility is not manne	y for Medication and Administration with an effective a review date of 6/2014 was o the use of electronic heading of Policy: Included tion of the policy is stated: button is utilized when the ed". No additional information ed to use of the electronic	-				
F 431 SS=E	1/2008 and revised Medication: All Sch double locked. Nat a locked med draw cabinet. 483.60(b), (d), (e) I LABEL/STORE DR The facility must er a licensed pharmac of records of receip	y RE: Narcotics Effective 7/14 lists under Schedule II nedule II Medications are kept rootic Books should be kept in er or the double locked DRUG RECORDS, UGS & BIOLOGICALS nploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an	F	431			

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Event ID: K7Z811

Facility ID: 00389

If continuation sheet Page 5 of 9

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STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245501	B. WING	· · · · · · · · · · · · · · · · · · ·	07/31/2014	
	PROVIDER OR SUPPLIEF	· · ·	1	TREET ADDRESS, CITY, STATE, ZIP CODE 907 KLEIN STREET ST PETER, MN 56082		
(X4) İD PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES 2Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIC	
F 431	accurate reconcilia records are in orde controlled drugs is reconciled. Drugs and biologic labeled in accorda professional princi appropriate access instructions, and th applicable. In accordance with facility must store locked compartme controls, and perm have access to the The facility must p permanently affixe controlled drugs lis Comprehensive Di Control Act of 1976 abuse, except whe package drug distr quantity stored is n be readily detected This REQUIREME by:	ation; and determines that drug er and that an account of all maintained and periodically cals used in the facility must be nce with currently accepted ples, and include the sory and cautionary ne expiration date when a State and Federal laws, the all drugs and biologicals in ints under proper temperature it only authorized personnel to a keys. rovide separately locked, d compartments for storage of sted in Schedule II of the rug Abuse Prevention and 5 and other drugs subject to en the facility uses single unit ibution systems in which the ninimal and a missing dose can	F 431	 F431 Drug Records, Label/Stor Drugs & Biologicals 1. Expired medication was immediately removed from the medication storage cabinets. 2. Residents have the potential be affected by expired medication To ensure resident safety, nurse will monitor dates on medication. 3. A review of the policies regarding expiration of medication and removal of those medication was reviewed with the nurses on 8/28/2014. 4. Primary day nurses will condu- weekly audits and a monthly aud each neighborhood will be completed by a staff nurse. On the spot education will be provided an needed. The policy and survey results were reviewed at the Qua Council meeting on 8/28/2014. 5. The Director of Nursing and Nurse Managers are responsible 	to ons. s s. ons is o uct lit of he is ality red	
	review the facility fa needed (PRN) med (R9, R71 & R84) w the medication roo the expiration date	ailed to dispose of expired as dications for 3 of 66 residents tho had medications stored in ms and the failure to monitor for PRN and stock on the resident standing orders		compliance. Initiated by Septem 11, 2014.		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES	3
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		WILDIOAD SERVICES			~		0000 0001
	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUILE		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245501	B. WING			07/	31/2014
NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY			•	19	TREET ADDRESS, CITY, STATE, ZIP CODE 907 KLEIN STREET T PETER, MN 56082	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	who reside in the fa Findings include: Observations of the were conducted on included two (2) me Angel/Butterfly and and eight nursing s R84 had a PRN (as Ondansetron (Zofra (mg) Tablets 1 PO h (hours). The exp and this medication 6/21/14, and verifie R84 had a PRN orc or Kaopectate) 2 m the medication had 2014. This medica 6/21/14, and verifie During review of the located on the Eagl 9:23 a.m. the follow of Loperamide Hydu used as a stock sup stock medication ar were listed as May available for PRN u physician approved	e medication storage areas 7/30/14, at 8:30 a.m. and edication rooms located on the Eagle/Dove resident wings tations. needed) order for an-anti-nausea) 4 milligram (per order) q (every) eight (8) iration date was noted as 3/14 was last administered on d by registered nurse (RN)-B. ler for Loperamide (Imodium g by mouth PO q4 hours and an expiration date of March tion was last administered on	F	131			
	capsule tid (three tir	r for Loperamide 2 mg PO 1 nes daily). The expiration ugust 2013. LPN-D was				ł	
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: K7Z811		Fac	ility ID: 00399 If continu	ation she	et Page 7 of 9

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		& MEDICAID SERVICES			OMB NO	<u>). 0938-039</u>	
STATEMENT OF DE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245501	B. WING		07	/31/2014	
NAME OF PROVID	ER OR SUPPLIER	······································	<u>·L</u>	STREET ADDRESS, CITY,		/31/2014	
BENEDICTINE	LIVING COMM	UNITY		1907 KLEIN STREET			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		ST PETER, MN 56082			
PREFIX	EACH DEFICIENCY	MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
	inued From pag		F4	31			
last a	idministered, b ing from the ca	when this medication was ut 8 doses were noted rd. This was verified by					
(1) bo statio LPN- unab admin	ottle was locate n #1 with the e D verified the e le to determine histered. Tylén	ssin (cough suppressant) one d in bottom drawer on Dove xpiration date of June 2014. expiration date, but was when last dose had been ol (analgesic) suppositories				·	
R71 h (Com Octob	D was unable t had been adm nad a PRN orde pazine) 10 mg	ration date of October 2013. o verify when the most recent inistered. er for Prochlorperazine PO with expiration date of D was unable to verify when					
7/30/1 Dulco ready expira 2014. capsu had a have 6 verifie verifie	4, at 9:40 a.m. lax suppositoring for use and it with A card of Lope les, which was a expiration dar d doses missing d the expiratior	ale nursing station #2 on one box containing 11 es which was available and was noted to have various veen July 2013 and July eramide Hydrochloride 2 mg available and ready for use, te of May 2014 and noted to g from the card. LPN-C in dates but was unable to e medications had last been					
at 9:23 routine storag for PR	a.m. and verifiely stored in the erooms and a N use. LPN-C ed medications	ere interviewed on 7/30/14, fied that medications were two main medication lso on the nursing stations & LPN-D further verified the s for R9, R71 and R84 were		acility ID: 00399	·····		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245501	B. WING	·		07	/31/2014	
NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1907 KLEIN STREET ST PETER, MN 56082						
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	/IDER'S PLAN OF CORRECTI CORRECTIVE ACTION SHOU EFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 431	been removed from when the weekly me completed. During an interview director of nursing (staff were to check time they were on d She also stated tha found to be outdate to remove the medi storage area and pl disposal.	ge 8 biration date and should have the medication storage areas edication checks were to be on 7/30/14, at 9:45 a.m. the DON) verified that nursing medications for outdates each uty and passing medications. t whenever a medication was d the nursing staff person was cation from the drawer or ace into a drawer labeled for	F 4.	31				
	dated 1/2013 and re following procedure #6. Drugs shall no expiration date on th or deteriorated drug weekly basis the nig refrigerator and drav remove them and d #11. All medication expire and those me residents at time of immediately withdra locked away separa in conformance with procedure. #14. Medications pr may be retained in s drawer. These shall the label and a date	evised 4/14 identified the to be kept on hand after the ne label and no contaminated is shall be available. On a ght nurse will check both the wers for expired medications, ispose per disposal policy. is on hand for residents who edications not sent home with						

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	IPLE CONSTRUCTION NG 02 - NEW BUILDING	(X3) DATE SURVEY COMPLETED
		245501	B. WING		07/29/2014
	PROVIDER OR SUPPLIER	UNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1907 KLEIN & TREET ST PETER, MN 56082	-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO
K 000	INITIAL COMMEN	rs	KO	00	
	FIRE SAFETY	OC WILL SERVE AS YOUR	:20	F00 This Plan of Correction is	
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.		submitted pursuant to the app Federal and State Regulations Nothing contained herein shal construed as an admission the Facility violated any Federal o States Regulations or failed to	s. I be at the r
	ONSITE REVISIT (CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.	J	POC K	
Ž	Minnesota Departm Fire Marshal Divisio time of this survey, of St. Peter was fou compliance with the in Medicare/Medica 483.70(a), Life Safe	Survey was conducted by the pent of Public Safety, State on, on August 13, 2013. At the Benedictine Living Communit and not to be in substantial requirements for participation id at 42 CFR, Subpart by from Fire, and the 2000	e y	W/TW'S tor P8 9-15-14	20 20
		Fire Protection Association fety Code (LSC), Chapter 18 ocupancies.	2	RECEIVE	97
	PLEASE RETURN CORRECTION FOI DEFICIENCIES (K-	R THE FIRE SAFETY	×.	SEP 1 0 2014	
EXIT.	Health Care Fire Ins State Fire Marshal I 445 Minnesota St., St. Paul, MN 55101 Facsimile: 651-215	Division Suite 145 -5145		MN DEPT. OF PUBLIC SA STATE FIRE MARSHAL DIV	FETY
ORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	aministrator NEO	9/9/2014

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	HS FOR MEDICARE	& MEDICAID SERVICES				OIVIB	NO. 0930-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	tipi 1NG	PLE CONSTRUCTION A 02 - NEW BUILDING	(X3) DATE SURVEY COMPLETED
		245501	B. WING	_		-	07/29/2014
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD	E	
BENEDI	CTINE LIVING COMM	UNITY			1907 KLEIN STREET ST PETER, MN 56082		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFID TAG	X	PROVIDER'S PLAN OF CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	E (X6) COMPLETION DATE
K 000	Continued From pa	age 1	ко)00			
	By e-mail to: Marian.Whitney@s	state.mn.us			N.		
		RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:					
	1. A description of to correct the defic	what has been, or will be, done lency.			1.50		
	2. The actual, or pr	oposed, completion date.					
	responsible for cor	r title of the person rection and monitoring to ence of the deficiency.			а К. Э.		
	constructed in 200 original building is basement of Type	Community of St. Peter was 6 at two different times. The a one story building with no V(111) construction. The d in 2006, with a link to the					.7
	hospital is a one st of Type V(111) con fire sprinkler protect separated from a h facility by 2-hour fir opening protectives	ory building with no basement struction. The building is fully oted. The nursing home is nospital and a senior housing re wall assemblies, with s consisting of labeled,			2		
	door assemblies. The building has a detection in the con corridors which is r department notifica automatic smoke c Because the origin meet the construct buildings, the 2 buildings	re latching, 90-minute fire rated fire alarm system with smoke monitored for automatic fire ation. The facility also has detection in all sleeping rooms. al building and the addition ion type allowed for new ildings will be surveyed as one y has a capacity of 79 beds		9	23 23 *-		а. Э
		Obsolate Event ID: K7782	1	E	Facility ID: 00399	ntinuation	n sheet Page 2 of 1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:K/2821

		AND HUMAN SERVICES & MEDICAID SERVICES			INTED: 08/25/2014 FORM APPROVED MB NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 22 - NEW BUILDING	(X3) DATE SURVEY COMPLETED
		245501	B. WING		07/29/2014
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
BENEDIC		UNITY		T PETER, MN 56082	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
K 000		ge 2 If 74 at time of the survey.	K 000	, ×	
K 011 SS=E	The requirement at NOT MET as evide NFPA 101 LIFE SA If the building has a nonconforming build barrier having at lea rating constructed of addition. Communi- corridors and are pu- self-closing fire door This STANDARD is Based on observat has failed to mainta the 2 required locat could affect the safe visitors in the event could affect the safe visitors in the event could pass from on- Findings include: On facility tour betw 07-29-2014, it was separation doors di the following location 1) The fire barrier d home and the hosp when tested. 2) The fire barrier d	42 CFR, Subpart 483.70(a) is need by: FETY CODE STANDARD common wall with a ding, the common wall is a fire ast a two-hour fire resistance of materials as required for the loating openings occur only in rotected by approved rs. 18.1.1.4.1, 18.1.1.4.2 s not met as evidenced by: ion and interview, the facility in the 2-hour fire separation at ions. This deficient practice ety of all residents, staff and of a fire, as fire and smoke e building to the other.	K 011	K011 NFPA 101 Life Safety Co Standard 1. Adjustments are being mad the fire barrier doors at the connection with the hospital an between buildings B and C to s close and latch. 2. The proposed completion d by September 9, 2014. 3. The Environmental Service Director is responsible for assu the latching and closure of the barrier doors.	e to nd self- ate is s uring

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Facility ID: 00399

If continuation sheet Page 3 of 12

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIPI	E CONSTRUCTION (X3) [O. 0938-039 ATE SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	D2 - NEW BUILDING	OMPLETED
		245501	B, WING		7/29/2014
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
BENEDI		IUNITY		907 KLEIN STREET T PETER, MN 56082	2
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 011	Continued From pa	age 3	K 011		
	These deficiencies				
K 018 SS=E		FETY CODE STANDARD	K 018	K018 NFPA 101 Life Safety Code Standard	
	constructed to resi Doors are provided hardware. Dutch d	orridor openings are st the passage of smoke. d with positive latching loors meeting 18.3.6.3.6 are atches are prohibited.	54 ^{- 1}	1. A latch is being installed on the break room door. The completion date is September 24, 2014.	
	Based on observa did not have corrid requirements of NI 19.3.6.3.2. This de	is not met as evidenced by: tion and interview, the facility or doors that meet the -PA 101 LSC (00) Section ficient practice could affect the ents within the smoke		 The linen door B226 was adjusted to assure the latch closed when tested. The completion date is September 5, 2014. The Environmental Services Director is responsible for assuring the work is completed and doors latch as required. 	3
	07-29-2014, it was doors	ween 9:30 AM and 3:00 PM on observed that the corridor the frame at the following			
	locations: 1) Staff Break Roo did not have a late	m door to the corridor F615			~
K 027	This deficiency was Service Director (D	as verified by Environmental B) at the time of discovery. FETY CODE STANDARD	K 027		Lie

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FORM	APPROVED
OHD NO	1000 000d

	T OF DEFICIENCIE\$ DF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT CON	E SURVEY
	PROVIDER OR SUPPLIER CTINE LIVING COMM		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 1907 KLEIN \$TREET ST PETER, MN 56082	07/	29/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
K 027	20-minute fire prote 1¾-inch thick solid protective plates that from the bottom of the Horizontal silding do Swinging doors are swings in an opposi self-closing and rab required at the mee	ge 4 action rating or are at least bonded wood core. Non-rated at do not exceed 48 inches the door are permitted. bors comply with 7.2.1.14. arranged so that each door te direction. Doors are bets, bevels or astragals are ting edges. Positive latching 3.7.5, 18.3.7.6, 18.3.7.8	K 0	27		
	Based on observati failed to maintain sm by NFPA 101 -2000 8.3.4, 8.3.4.1, 8.3.4. practice could all res compartments. Findings include: On facility tour betwee 07-29-2014, it was o inch gap at the meet cross-corridor smoke The doors did not ha gap.	een 9:30 AM and 3:00 PM on bserved that there was a 1/2		 K027 NFPA 101 Life Safety Standard 1. An astragal has been order and will be installed on the sr barrier doors by room A136. 2. The completion date is September 24, 2014. 3. The Environmental Servic Director is responsible for ass the work is completed. 	ered noke es	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING 0	CONSTRUCTION 2 - NEW BUILDING	(X3) DATE COM	E SURVEY PLETED
		245501	B. WING		07/2	29/2014
	PROVIDER OR SUPPLIER	UNITY	19	REET ADDRESS, CITY, STATE, ZIP CODE 07 KLEIN STREET 17 PETER, MN 56082		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X6) COMPLETK DATE
K 027		ige 5 B) at the time of discovery.	K 027			
K 029 SS=F	NFPA 101 LIFE SA	FETY CODE STANDARD	K 029	K029 NFPA 101 Life Safety Standard	Code	
	with 8.4. The area fire-rated barrier, w without windows (in	tre protected in accordance s are enclosed with a one hour rith a 3/4 hour fire-rated door, n accordance with 8.4). Doors automatic closing in 2.1.8. 18.3.2.1		1. The soiled utility room doe and corridor door to the kitch room F604 were adjusted to the self-closure was operatio the door latched. The magne holding the storage room doo was removed.	en assure onal and et	
<u>1</u>	Based on observa failed to provide pr accordance with th -2000 edition, Sect	s not met as evidenced by: tion and interview, the facility otection of hazardous areas in e requirements of NFPA 101 ion 18.3.6.2. This deficient ct staff patients and visitors ompartment.		 2. The completion date is Au 28, 2014. 3. The Environmental Servic Director is responsible for as the work is completed and do latch as required. 	ces suring	
	07-29-2014, it was 1) Soiled Utility roo did not self close a 2) Storage Room of	m door to the corridor D418 nd latch when tested. loor to the corridor F610 was agnet which does not release	а.	21 (P) 72		9.
	 Corridor door to not self close and I These deficiencies Environmental Ser of discovery. 	the Kitchen By room F604 did atch when tested. s were verified by vice Director (DB) at the time		ā		4
K 050 SS=C	Fire drills are held varving conditions.	FETY CODE STANDARD at unexpected times under at least quarterly on each shift. r with procedures and is aware	K 050			

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CENTER	IS FOR MEDICARE	& MEDICAID SERVICES		and the second se	JUIN DATE CUDVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG 02 - NEW BUILDING	(X3) DATE SURVEY COMPLETED
		245501	B. WING _		07/29/2014
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BENEDIC	TINE LIVING COMM	UNITY	-	1907 KLEIN STREET ST-PETER, MN 56082	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EAGH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
K 050	that drills are part of Responsibility for p assigned only to co qualified to exercis conducted between	of established routine. Ianning and conducting drills is Impetent persons who are I leadership. Where drills are In 9 PM and 6 AM a coded I be used instead of audible	K 0!	50	
• •	Based on review of interview,, it was d to conduct fire drill LSC (00) Section	is not met as evidenced by: of reports, records and etermined that the facility failed s in accordance with NFPA 101 19.7.1.2. This deficient practice taff react in the event of a fire.		K050 NFPA 101 Life Safety of Standard 1. The fire drill schedule was reworked to assure drills are throughout a shift and not overlapping.	-
K 052 SS=F	07-29-2014, based documentation it w not varied through shifts: Drills are conducted however, during the conducted betwee period. During the conducted during period. This deficiency wa Service Director (I NFPA 101 LIFE S/ A fire alarm system installed, tested, a with NFPA 70 Nati	ween 9:30 AM and 3:00 PM on d on review of available vas reveled that fire drills were out the evening and night ad one per shift per quarter the evening shift 3 of 4 drills are n the 2:30 PM 3:10 PM time e night shift 3 of 4 drills are the 2:00 AM to 3:00 AM time as verified by Environmental DB) at the time of discovery. AFETY CODE STANDARD in required for life safety is and maintained in accordance ional Electrical Code and NFPA as an approved maintenance im complying with applicable	к	 2. The completion date is Au 28, 2014. 3. The Environmental Servic Director is responsible for as fire drills rotate throughout a period. 	es suring

FORM CM8-2567(02-99) Previous Versions Obsolete

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Facility ID: 00399

If continuation sheet Page 7 of 12

PRINTED: 08/25/2014 FORM APPROVED

_CENTER	AS FOR MEDICARI	E & MEDICAID SERVICES			OWR NO.	0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245501		TIPLE CONSTRUCTION NG 02 - NEW BUILDING	COM	E SURVEY PLETED 29/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	Lormott
	CTINE LIVING COMM		8	1907 KLEIN STREET ST PETER, MN 56082		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 052 K 056 SS≠E	This STANDARD Based on review a failed to properly n accordance with N 9.6.1.4. This defic occupants includin Findings include: On facility tour bett 07-29-2014, It was available fire alarm 1) The fire alarm s not conducted on a The testing from 1 was more than 12 2) Mechanical Roo smoke detector dir panel. This deficiency wa Service Director (D NFPA 101 LIFE SA There is an autom in accordance with Installation of Sprir components, devic complete coverage The system is mai NFPA 25, Standard and Maintenance o Systems. There is	FPA 70 and 72. 9.6.1.4 is not met as evidenced by: and interview, the facility has naintain the fire alarm system in IFPA 72, 1999 Edition. Section lent practice could affect all g residents, staff and visitors. ween 9:30 AM and 3:00 PM on a revealed during review of n documentation that: ystem tests and inspection was an annual basis. 0-18-12 to testing of 11-20-13	KO	 K052 NFPA 101 Life Safety Standard 1. Fire alarm system tests inspections will be conducte annual basis and completed 12 month period. The comp date was July 31, 2014. 2. A request for a tempora waiver for K052 is being ma 12/31/2014 to install a smok detector directly above the r alarm panel in Room F618. 3. The Environmental Servi Director is responsible for a the inspections are held on annual basis. 	and d on an within a letion ry de until ce nain fire	12/31/2
				9.1		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:K72821

Facility ID: 00398

If continuation sheet Page 8 of 12

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3 02 - NEW BUILDING		SURVEY PLETED
	i.	245501	B. WING		07/2	29/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1907 KLEINSTREET ST PETER, MN 56082		M
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 056		tamper switches which are	K 056	6	2	,
K 076 SS=F	Based on observa revealed that the a is not in Installed in Standard for the In (1999 edition). This negatively impact a staff. Findings include: On facility tour betw 07-29-2014, it was Sprinkler heads we handling Mechanic were above ducts I inches in width. These deficiencies Environmental Ser of discovery. NFPA 101 LIFE SA Medical gas storag protected in accord for Health Care Fac (a) Oxygen storage	ere obstructed in the two air al Rooms. Sprinkler heads but not below. Ducts were 52 a were verified by vice Director (DB) at the time FETY CODE STANDARD e and administration areas are lance with NFPA 99, Standards	K 076	 K056 NFPA 101 Life Safety Standard 1. A request for a temporary for K056 is being made until 12/31/2014 to install sprinkle in the air handling mechanica rooms to meet the requirement NFPA 13. 2. The Environmental Service Director is responsible for as the work is completed. 	waiver r heads al ents of ess	12/3

PRINTED: 08/25/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	12-2-2-2
		245501	B. WING		07/29/2014	
	PROVIDER OR SUPPLIER CTINE LIVING COMM	ŲΝΙΤΎ		STREET ADDRESS, CITY, STATE, ZIP CODE 1907 KLEINSTREET ST PETER, MN 56082		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET	TION
K 1.43 SS=E	3,000 cu.ft. are ven 4.3.1.1.2, 18.3.2.4 This STANDARD is Based on observati was not stored in an Standards for Healt This deficient practi- residents, visitors a compartment. Findings include: On facility tour betw 07-29-2014, it was The Oxygen Storag bottle not secured in This deficiency was Service Director (DI NFPA 101 LIFE SA Transferring of oxyg (a) separated from wherein patients and treated by a separa fire-resistive constru- treated by a separa fire-resistive constru- (b) in an area that is sprinklered, and has and (c) in an area poste transferring is occur immediate area is n	ted to the outside. NFPA 99 s not met as evidenced by: tion and interview, medical gas coordance with NFPA 99, theare Facilities. ice could negatively impact all nd staff within the smoke veen 9:30 AM and 3:00 PM on observed that: le room B236 had an oxygen n its holder. everified by Environmental B) at the time of discovery. FETY CODE STANDARD gen is: any portion of a facility e housed, examined, or tion of a fire barrier of 1-hour uction; s mechanically ventilated, s ceramic or concrete flooring; d with signs indicating that rring, and that smoking in the not permitted in accordance he Compressed Gas	К 07	 K076 NFPA 101 Life Safety C Standard 1. Oxygen bottles will be secu a holder. 2. The completion date was 7/29/2014. 3. The Nurse Managers will be responsible to monitor the oxy storage rooms and assure that oxygen bottles are secured in holders. 	red in e gen	

FORM CMS-2567(02-99) Previous Versions Obsolate

Event ID:K7Z821

Facility ID: 00399

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If continuation sheet Page 10 of 12

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (FACH CORRECTIVE ACTION SHOULD BE COMPL	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3 02 - NEW BUILDING	(X3) DATE	U938-U39 SURVEY PLETED
BENEDICTINE LIVING COMMUNITY 1907 KLEIM STREET ST PTER, M 56082 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LGS DEMIFYING INFORMATION) PREFIX TAG PROVERTS FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLLD BE CROSH REFERENCED TO THE APPOPRIATE DEFICIENCY) 000 (EACH CORRECTIVE ACTION SHOLLD BE (EACH CORRECTIVE ACTION SHOLLD BE CROSH REFERENCED TO THE APPOPRIATE DEFICIENCY) 000 (EACH CORRECTIVE (EACH CORRECTIVE ACTION SHOLLD BE (EACH CORRECTIVE Based on observation, the facility transfer/oxygen storage room a non-compliant room with NFPA 99 and the Compresed Gas Association. 8.6.2.5.2 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. 2. The completion date is August 28, 2014. 3. The Environmental Services Director is responsible for assuring the door latches as required. 1. The extension cord was removed from the laundy room and the power strips were removed from usage with therapy quipment and in mechanical shop. 1. The completion date is August 28, 2014. 2. The completion date is August 28, 20			245501		· · · · · · · · · · · · · · · · · · ·	07/2	29/2014
PREFIX TAG (EACH DEFICENCY MUST BE PRECEDED BY FULL REQULATORY OR LSD DENTIFYING INFORMATION) PREFX TAG (EACH DEFICENCY MUST BE PRECEDED BY FULL CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) (Continued Prom Section Sectin Sectin Section Section Section Section Section Sect		CTINE LIVING COMM	the second se		1907 KLEIN STREET ST PETER, MN 56082		
 K 147 <	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	DBE	(X5) Completion Date
 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 corlidor D433 did not self close and latch when tested. This deficiency was verified by Environmental Service Director (DB) at the time of discovery. K 147 K 147 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 intervew, 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: Main Laundry Room had an extension cord 	K 143	This STANDARD	s not met as evidenced by:	К 14	K0143 NFPA 101 Life Safety (Code	*
 did not self close and latch when tested. This deficiency was verified by Environmental Service Director (DB) at the time of discovery. NFPA 101 LIFE SAFETY CODE STANDARD K 147 KSS=E 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 intervew, the facility has falled 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 K 147 <	х х	storage room a non 99 and the Compre 8.6.2.5.2 This deficient practi residents, staff and compartment. Findings include: On facility tour betw 07-29-2014, it was	veen 9:30 AM and 3:00 PM on observed that the Case of the		D433 was adjusted to assure t door latched. 2. The completion date is Aug 28, 2014. 3. The Environmental Service Director is responsible for assu	he iust s	
 This STANDARD is not met as evidenced by: Based on observation and intervew, 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: Main Laundry Room had an extension cord power strips were removed from usage with therapy equipment and in mechanical shop. The completion date is August 28, 2014. The Environmental Services Director is responsible for assuring that no extension cords are utilized in the facility. 		did not self close ar This deficiency was Service Director (DI NFPA 101 LIFE SAI Electrical wiring and	nd latch when tested. s verified by Environmental B) at the time of discovery. FETY CODE STANDARD d equipment is in accordance	K 14	 K0147 NFPA 101 Life Safety C Standard The extension cord was rem 		1. 10.05 - 10.
Director is responsible for assuring that no extension cords are utilized in the facility.		Based on observat has failed to ensure being used as a suk This deficient practi	ion and intervew, the facility that extension cords are not ostitute for permanent wiring ce could affect the safety of all	Ś	power strips were removed from usage with therapy equipment in mechanical shop. 2. The completion date is Augu 28, 2014.	and ust	
		On facility tour betw 07-29-2014, it was (1) Main Laundry Ro	observed that: om had an extension cord		Director is responsible for assu that no extension cords are util	ring	

PRINTED: 08/25/2014
FORM APPROVED

CENTER	AS FOR MEDICARE	A MEDICAID SE	RVICES				0		0990-0991
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUP IDENTIFICATION	PLIER/CLIA			CONSTRUCTION	-	(X3) DATE COM	SÚRVEY PLETED
		24550	01	B. WING			+	07/2	9/2014
NAME OF I	PROVIDER OR SUPPLIER					EET ADDRESS, CITY,	STATE, ZIP CODE		
BENEDI	CTINE LIVING COMM	UNITY	10 INT ATUR 1			7 KLEIN STREET PETER, MN 5608			·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIEN Y MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	id Prefi Tag		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTIO TIVE ACTION SHOULD ICED TO THE APPROP EFICIENCY)	N Dibe Riate	(X6) Completion Date
К 147	Continued From pa 2) Therapy Room I connected to an ex 3) Mechanical Sho Directors office had Microwave and mu used for charging to This deficiency wa	had an extension ercise machine. p by by Environm d a power strip plu iti plug adapter pl patteries. Is verified by Envi	ental ugged into a ugged in ronmental	К 1	47	а л х х	я ¹		ја 190
	Service Director (D	B) at the time of (discovery.	2		12	- 2		
	ig é é	<u>6</u>	5						
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ORM CMS-25	87(02-99) Previous Versions	Obsolete	Event ID:K7Z82	21	Facili	ty ID: 00399	li continua	tion sheet	Page 12 of 12



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 <u>only a suggestion</u> 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 <u>Kathryn.serie@state.mn.us</u> 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,

Kumalu 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

Minneso	ta Department of He	alth			i orani	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	
		00399	B. WING		07/3	1/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE LIVING COMM		IN STREET R, MN 56082	2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated du corrected.	rule provided at the tag ile number indicated below. In several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was hearing on any assessments				
	that may result from orders provided that the Department with	n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
Aincocoto D	Department's staff of the following licensi corrections are com on the bottom of the with "Laboratory Dir	S: and 7/24/14, surveyors of this visited the above provider and ng orders were issued. When apleted, please sign and date e first page in the line marked rector's or Provider/Supplier gnature." Make a copy of		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to	

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

TITLE

(X6) DATE

K7Z811

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00399	B. WING		07/3	1/2014
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, EIN STREET	STATE, ZIP CODE		
BENEDI			R, MN 5608			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ige 1	2 000			
	these orders for you original to the addre Department of Hea Monitoring, Licensin 1400 E. Lyon Stree Minnesota Department the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag n column entitled "ID statute/rule out of co "Summary Statement and replaces the "T correction order. The findings which are in after the statement evidence by." Follow are the Suggested Time period for Con PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC MINNESOTA STAT MN St. Statute 144 Residents of HC Fa Subd. 16. Confide	ur records and return the ess below: Minnesota lth, Division of Compliance ng and Certification Program, t, Marshall, MN 56258 nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for umber appears in the far left Prefix Tag." The state compliance is listed in the ent of Deficiencies" column to Comply" portion of the his column also includes the n violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection. ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.	21860	The assigned tag number app far left column entitled "ID Pro The state statute/rule number corresponding text of the state out of compliance is listed in t "Summary Statement of Defice column and replaces the "To 0 portion of the correction order column also includes the find are in violation of the state state statement, "This Rule is not m evidenced by." Following the findings are the Suggested Mc Correction and the Time Period Correction. PLEASE DISREGARD THE H THE FOURTH COLUMN WH STATES, "PROVIDER'S PLAN CORRECTION." THIS APPLIN FEDERAL DEFICIENCIES ON WILL APPEAR ON EACH PAC THERE IS NO REQUIREMEN SUBMIT A PLAN OF CORRECTIONS OF MINNESOT STATUTES/RULES.	efix Tag." and the e statute/rule he iencies" Comply" . This lings which tute after the let as surveyors ethod of d For IEADING OF ICH N OF ES TO NLY. THIS GE. IT TO CTION FOR	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00399						E SURVEY PLETED
		B. WING	07/	07/31/2014		
AME OF F		R STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ENEDIC	TINE LIVING COM		EIN STREET R, MN 56082			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES XY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
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.					
	by: Based on observa review the facility of confidentiality of m the electronic med R39, R57 R84 & F during the medica Findings include: During observation nursing station #1 7/29/14, at 7:30 p. (LPN)-A was obse R84 and then walk	nent is not met as evidenced tion, interview and document failed to ensure the nedical information located in dical record for 4 of 4 residents (103) who were observed tion pass was maintained.				
	R84's personal an computer screen I was visible to resid	was left open and displayed d medical information. This ocated on the nursing station dents, staff and/or visitors who id/or around the dining area.				

	ta Department of He	ealth	-			APPROVE	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00399				CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NOMBER.	A. BUILDING:		COM	GOWFLETED	
		B. WING		07/	31/2014		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
	CTINE LIVING COMM	1907 KLE	EIN STREET				
DENEDI		ST PETE	R, MN 56082				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC		(X5) COMPLETE	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE	
21860	Continued From pa	age 3	21860				
	The information dis	splayed on the computer					
	screen included a	photo of R84, diagnoses,					
		ationale 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 c	bservation 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						
		A then returned to the nursing					
		. Various staff, residents and					
		ved passing through the area					
		er screen displayed R39's					
		n. At 7:45 p.m. LPN-A					
		y the medical information of					
	•	outer screen while she stepped					
		e narcotic book and prepared atch for R39. LPN-A then					
		edications she had					
		closed the computer screen.					
		nformation was visible and					
	unmonitored for a	total of 13 minutes.					
	During observation	of the medication pass on					
	7/30/14, at 8:22 a.r	m. registered nurse (RN)-B					
	was observed pass	sing medications from nursing					
	station #1. RN-B opened the computer screen						
		photo, medications with reason					
		and diagnoses. RN-B prepared	1 I				
		alked away from the station ter screen open which					
		onal information. RN-B					
		from the dining area into her					
nnesota D	epartment of Health		ji l			<u> </u>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00399		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED		
				07/	07/31/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
BENEDIC	TINE LIVING COMM	LINITY	EIN STREET R, MN 56082			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21860	Continued From pa	age 4	21860			
	a.m. and then retur a.m. The computer the medical informa- when RN-B closed computer screen. visible to anyone in 17 minutes. The in- visualized by other who were present.	blood glucose level at 8:25 rned to the dining area at 8:27 r screen remained opened with ation displayed until 8:39 a.m. the information on the Medical information was the area of nursing station for formation could be easily residents, visitors and/or staff				
	7/31/14, at 7:45 a.r nursing station #21 LPN-B opened the R57's personal me prepared R57's ins nursing station to the where the insulin we computer screen we through or seated in time frame, two rest one housekeeping dining area. All of walk past the nursi screen was left una computer terminal	n. LPN-B was located on located on the Angel wing. computer screen to display dical information. LPN-B then ulin, walked away from the ransport R57 into his room vas administered. The vas viewable to anyone passing n the dining area. During this sidents, one dietary staff and personnel were present in the these individuals were noted to ng station where the computer attended and open to view. The was viewable and unattended LPN-B left the area of the				
	station during the ti 7/30 and 7/31/14 to on the counter at th book was accessib could have access	observations of the nursing ime period of 7/28/14, 7/29, hat narcotic records remained ne nursing stations. The record le for review and the public to information related to ces and the amount/types of the nurses station.				
	During an interview	/ on 7/31/14, at 9:23 a.m. the				

	ta Department of He			CONCEPTION			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING	B. WING		07/31/2014		
		ADDRESS, CITY, S			01/01/2014		
		1907 K	LEIN STREET				
BENEDIC	CTINE LIVING COMM	ST PET	ER, MN 56082				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21860	Continued From pa	age 5	21860				
	of resident informa medical record. T personal informatic clicking the "walk a when staff left the r resident medication purpose of this but and medical inform attendance. The D computer screen s inappropriate for st that it could be view	eeen to maintain confidentiality tion located in the electronic he DON indicated that reside on was to be protected by way" button on the computer nursing station to administer ns. The DON verified the ton was to protect personal action when staff were not in DON further verified the hould be closed and that it wa aff to leave the screen open s wed by persons who were in bund the nursing stations	nt				
	narcotic records we at the individual nu private information controlled medicati	w the DON also verified that ere to be stored in the cabine rsing stations to protect the of the residents who received ons and not on the counter s were accessible for review.					
	Treatment Orders/, date of 3/2011 and completed related records. Under the under the sixth sec "eMAR walk away facility is not manne	ey for Medication and Administration with an effective a review date of 6/2014 was to the use of electronic e heading of Policy: Included etion of the policy is stated: button is utilized when the ed". No additional information ed to use of the electronic					
	1/2008 and revised Medication: All Sci double locked. Na a locked med draw	cy RE: Narcotics Effective I 7/14 lists under Schedule II hedule II Medications are kep rcotic Books should be kept in ver or the double locked					
nnesota De TATE FORM	epartment of Health		6899	7Z811	lé a antiau	ation sheet	

K7Z811

Minnesota Department of Health								
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED				
		00399	B. WING		07/31/2014			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
BENEDI	CTINE LIVING COMM		IN STREET R, MN 56082	2				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE			
21860	cabinet. SUGGESTED MET The DON could ins importance of confi resident information screen while staff w and/or not utilizing f periodic audit could compliance and the communicated to th committee. TIME PERIOD FOR (21) days.	THOD OF CORRECTION: ervice staff regarding the dentiality and privacy of n displayed on the computer vere not present in the area the computer screen. An I be conducted to ensure	21860					
	epartment of Health							

K7Z811