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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: KN4F

Facility ID: 00413

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245502**
2.STATE VENDOR OR MEDICAID NO.
(L2) **254740600**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE CARE COMMUNITY**
(L4) **201 9TH STREET WEST**
(L5) **ADA, MN** (L6) **56510**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2008**
6. DATE OF SURVEY **12/16/2014** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **49** (L18)
13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 12/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 12/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00320 (L31)

30. REMARKS
Posted 12/29/2014 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
12/12/2014 (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245502

December 16, 2014

Mr. Tyler Hoemberg, Administrator
Benedictine Care Community
201 9th Street West
Ada, Minnesota 56510

Dear Mr. Hoemberg:

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 November 30, 2014 the above facility is certified for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 skilled nursing facility beds.

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 16, 2014

Mr. Tyler Hoemberg, Administrator
Benedictine Care Community
201 9th Street West
Ada, Minnesota 56510

RE: Project Number S5502025

Dear Mr. Hoemberg:

On November 10, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 23, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On December 16, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 23, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 30, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 23, 2014, effective November 30, 2014 and therefore remedies outlined in our letter to you dated November 10, 2014, will not be imposed.

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245502	A. Building B. Wing	12/16/2014

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **11/30/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **11/30/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **11/30/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **11/30/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	12/16/2014	28035	12/16/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/23/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: KN4F

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00413

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(L1) **245502**

2.STATE VENDOR OR MEDICAID NO.
(L2) **254740600**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE CARE COMMUNITY**
(L4) **201 9TH STREET WEST**
(L5) **ADA, MN** (L6) **56510**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2008**

6. DATE OF SURVEY **10/23/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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13.Total Certified Beds 49 (L17)

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Theresa Gullingsrud, HFE NEII 11/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 12/08/2014 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
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11/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 10, 2014

Mr. Tyler Hoemberg, Administrator
Benedictine Care Community
201 9th Street West
Ada, MN 56510

RE: Project Number S5502025

Dear Mr. Hoemberg:

On October 23, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the October 23, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Supervisor
Bemidji Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

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 December 2, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- Address how the facility will identify other residents having the potential to be affected

by the same deficient practice;

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 23, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 23, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

5502s15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	10/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE CARE COMMUNITY	**201 9TH STREET WEST ADA, MN 56510**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning and incontinence care for 2 of 2 residents (R31 ,R4) according to the care plan. In addition, the facility failed to apply a left knee brace for 1 of 1 resident (R30) according to the care plan. Findings include: R31's care plan edited 8/12/14, indicated R31 was to be repositioned and toileted every 2 hours.	F 282	R31 & R4 will receive timely repositioning and incontinence care according to their plan of care. DON will ensure that CNAs are communicating repositioning and toileting between and during shifts by daily auditing residents cares and CNA flowsheets. All residents will be assessed by DON/designee to ensure they have appropriate repositioning & toileting program in place. Care plans will be adjusted as changes are made. Staff will be educated at monthly staff meeting on November 20th. DON/designee will	11/30/14

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

Electronically Signed | 11/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	10/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE CARE COMMUNITY	**201 9TH STREET WEST ADA, MN 56510**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 On 10/22/14, from 7:03 a.m. until 9:48 a.m. R31 was continuously observed seated in a wheelchair at a table in the common area without a change in position. On 10/22/14, at 9:48 a.m. nursing assistant (NA)-B stated R31 was to be toileted and repositioned every 2 hours, but she had not done so yet. At this time, NA-B was observed to assist R31 onto the toilet. NA-B stated it was difficult to get everyone toileted on time in the mornings, as it was very busy. NA-B provided peri cares and applied a new incontinent brief for R31 and assisted her back to her wheelchair. On 10/22/14, at 2:57 p.m. NA-E stated she was unsure what time R31 was last repositioned or toileted as R31 was already up for the day when she arrived to work at 6:00 a.m. On 10/23/14, at 9:03 a.m. NA-A stated she had not toileted or repositioned R31 the morning of 10/22/14. NA-A also stated R31 was up in her wheelchair when the day shift came to work at 6:00 a.m. on 10/22/14. On 10/23/2014, at 10:39 a.m. registered nurse (RN)-A stated she had contacted the night shift NA, NA-G, who indicated R31 was assisted up from bed at approximately 5:45 a.m. on 10/22/14, which indicated four hours and three minutes between R31's positioning and toileting assistance. RN-A confirmed R31 should have been toileted and repositioned every 2 hours as indicated on the care plan. RN-A verified the care plan was not followed. On 10/23/2014, at 10:44 a.m. director of nursing (DON) confirmed R31 should have been toileted	F 282	perform daily audits to ensure staff are repositioning & toileting residents per their plan of care. Audits will be reviewed at Quality Council on November 26th, 2014. R30 will receive brace for left lower extremity according to plan of care. Plan of Care was updated on 11/15/2014 that added order to have the nurse ensure knee brace be applied in the AM and removed at HS.	

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F 282	Continued From page 2 and repositioned every 2 hours as directed by the care plan. R4's care plan edited 9/16/14, indicated R4 was to be repositioned and toileted every 2 hours during the day. On 10/22/14, at 7:20 a.m. NA-A and NA-E were observed to provide R4 incontinence care and at 7:25 a.m. were observed to transfer R4 into a wheelchair. On 10/22/14, at 10:55 a.m. NA-A stated NA-D helped her put R4 on the toilet at 10:00 a.m. NA-A stated at that time, R4 was incontinent of urine. NA-A verified R4 was last assisted with incontinence care at 7:20 a.m. (2 hours and 40 minutes earier) and was placed in the wheelchair at 7:25 a.m. (2 hours and 35 minutes later). On 10/23/14, at 9:56 a.m. RN-A confirmed R4 was to be toileted and repositioned every two hours during the day as the care plan directed. RN-A verified R4's care plan was not followed. R30s care plan edited 10/2/14, indicated R30 was to wear a brace to her left lower extremity for support during transfers and ambulation daily. On 10/20/14, at 5:50 p.m. and 10/21/14, at 1:30 p.m. and again on 10/22/14, at 12:45 p.m. R30 was not observed to have her left knee brace on. On 10/23/14, at 9:05 a.m. RN-A stated according	F 282		

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F 282	Continued From page 3 to R30's care plan, the left knee brace was to be worn daily. RN-A verified R30's care plan was not followed. The undated Care plan policy indicated all residents would have a comprehensive care plan that would include measurable objectives and timetables to meet the resident's nursing needs.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning for 2 of 2 residents (R31, R4) who were identified at risk for the development of pressure ulcers (PU). Findings include: R31 was at risk for pressure ulcers and did not receive repositioning assistance for 4 hours on 10/22/14. The undated Resident Admission Record indicated R31 had diagnoses that included	F 314	R31 & R4 will receive timely repositioning care according to their plan of care. DON will ensure that CNAs are communicating repositioning between and during shifts by daily auditing residents cares and CNA flowsheets. All residents will be assessed by DON/designee to ensure they have appropriate repositioning program in place. Care plans will be adjusted as changes are made. Staff will be educated at monthly staff meeting on November 20th. DON/designee will perform daily audits to ensure staff are repositioning residents per their plan of care. Audits will	11/30/14

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F 314	Continued From page 4 dementia, debility, weakness, difficulty in walking, and late effects of poliomyelitis. R31's quarterly Minimum Data Set (MDS) dated 7/25/14, indicated R31 had severe cognitive impairment and required extensive assist of one for bed mobility, transfer, dressing, toilet use and personal hygiene R31's Pressure Ulcer Care Area Assessment dated 5/3/14, identified R31 was at risk for skin breakdown and pressure ulcers due to frequent urinary incontinence. R31's care plan edited 8/12/14, directed staff R31 required assistance of one person for peri cares twice daily and as needed, after any incontinence. The care plan also directed staff to reposition R31 every 2 hours. R31's Skin Risk Assessment dated 10/18/14, identified R31 was at moderate risk for the development of pressure ulcers due to mobility and self care deficits, dementia, depression and bowel and bladder incontinence. The skin assessment also identified R31 required a repositioning and toileting schedule with twice daily and as needed peri cares (cleaning of the genital and rectal areas). R31's Tissue Tolerance (a tool to determine the length of time skin can withstand pressure without change) dated 10/18/14, identified R31 required repositioning every 2 hours and as needed with off-loading pressure for at least one minute. On 10/22/14, from 7:03 a.m. until 9:48 a.m. R31 was continuously observed seated in a wheelchair at a table in the common area without	F 314	be reviewed at Quality Council on November 26th, 2014.	

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F 314	Continued From page 5 a change in position. On 10/22/14, at 9:48 a.m. nursing assistant (NA)-B stated R31 was to be toileted and repositioned every 2 hours, but she had not done so yet that morning. NA-B was observed to bring R31 to her bathroom and assist R31 onto the toilet. R31's incontinent brief was observed saturated with urine and had a strong ammonia odor. R31's right buttock was observed to have a raised welt approximately 1 1/2 inches long by 1/8 inch wide. NA-B stated the welt was not there previously and it looked like it was caused by a wrinkle in R31's incontinent brief. NA-B stated it was difficult to get everyone toileted on time in the mornings, as it was very busy. NA-B was observed to provide R31 peri cares, apply a new incontinent brief and and assist R31 back to her wheelchair. On 10/22/14, at 1:31 p.m. R31's buttocks were again observed during toileting assistance and the raised welt was no longer visible. On 10/22/14, at 2:29 p.m. NA-B stated she did not get R31 up for the day but that repositioning times were documented on care sheets carried by the NAs. NA-B indicated the care sheet was already given to NA-F who was working the next shift. NA-F stated the time R31 rose for the day was not documented on the care sheet but indicated NA-E may have gotten R31 up for the day. On 10/22/14, at 2:57 p.m. NA-E stated R31 was already up for the day when she arrived to work at 6:00 a.m. On 10/23/14, at 9:03 a.m. NA-A stated she had	F 314		

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F 314	Continued From page 6	F 314		

not repositioned R31 the morning of 10/22/14. NA-A also stated R31 was already up in her wheelchair when the day shift came to work at 6:00 a.m. on 10/22/14.

On 10/23/2014, at 10:39 a.m. registered nurse (RN)-A stated she had contacted the night shift NA, NA-G, who indicated R31 was assisted up out of bed at approximately 5:45 a.m. on 10/22/14, which indicated R31 was not repositioned for four hours and three minutes on 10/22/14. RN-A confirmed R31 was not repositioned every two hours as directed by the care plan.

On 10/23/2014, at 10:44 a.m. the director of nursing (DON) confirmed R31 should have been repositioned every 2 hours as directed by her care plan.

R4 was at risk for pressure ulcers and did not receive repositioning assistance for 2 hours and 35 minutes on 10/22/14.

R4's quarterly MDS dated 8/29/14, indicated R4 had dementia with severely impaired decision making skills. The MDS also indicated R4 was at risk for the development of PUs.

R4's care plan edited 9/16/14, indicated R4 was to be repositioned at least every 2 hours and as needed.

R4's The Skin Risk Assessment dated 10/1/14, indicated R4 was to be repositioned every 2 hours.

On 10/22/14, from 7:08 a.m. until 9:48 a.m. R4

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F 314	Continued From page 7 was continously observed: -at 7:08 a.m. NA-A was observed providing R4 morning cares. -at 7:25 a.m. NA-A and NA-E were observed to transfer R4 into the wheelchair. -at 9:48 a.m. R4 was observed to remain seated in the wheelchair without repositioning assistance. On 10/22/14, at 10:50 a.m. R4 was observed seated in the wheelchair in front of the TV. On 10/22/14, at 10:55 a.m. NA-A stated R4 was on an every two hour repositioning schedule. NA-A stated if she was busy with another resident and R4's two hour time frame was up, as soon as she was able she would get help to reposition R4. NA-A further stated repositioning did not have to be at exactly 2 hours, that it might be 15 minutes before or 15 minutes after. NA-A verified R4 was placed into his wheelchair and last repositioned at 7:25 a.m. (2 hours and 35 minutes later). At 12:34 p.m. NA-D verified at 10:00 a.m. she had assisted NA-A to reposition / toilet R4. On 10/23/14, at 9:56 a.m. RN-A confirmed R4 was at moderate risk for skin breakdown. RN-A stated R4 was to be repositioned every two hours during the day as directed by the care plan. RN-A verified R4's care plan was not followed. The undated Turning and Repositioning policy indicated every resident would receive the necessary turning and repositioning to meet their specific needs.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		11/30/14

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F 315	Continued From page 8 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely incontinence care / toileting assistance for 2 of 3 residents (R31,R4) according to their assessed needs. Findings include: R31 did not receive toileting assistance for 4 hours on 10/22/14. The undated Resident Admission Record indicated R31's diagnoses included dementia, debility, weakness, difficulty in walking, late effects of poliomyelitis and urinary incontinence. R31's quarterly Minimum Data Set (MDS) dated 7/25/14, indicated R31 had severe cognitive impairment and required extensive assist of one for bed mobility, transfer, dressing, toilet use and personal hygiene R31's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated	F 315	R31 & R4 will receive timely incontinence care according to their plan of care. DON will ensure that CNAs are communicating toileting between and during shifts by daily auditing residents cares and CNA flowsheets. All residents will be assessed by DON/designee to ensure they have appropriate toileting program in place. Care plans will be adjusted as changes are made. Staff will be educated at monthly staff meeting on November 20th. DON/designee will perform daily audits to ensure staff are toileting residents per their plan of care. Audits will be reviewed at Quality Council on November 26th, 2014.	

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F 315	Continued From page 9	F 315		

5/3/14, indicated R31 required extensive assistance with toileting and had frequent incontinence. The CAA indicated R31 required assistance as needed for toileting every 2 hours throughout the day and every 4 hours at night.

R31's care plan edited 8/12/14, directed staff R31 required assistance of one person for peri cares twice daily and as needed, after any incontinence. The care plan also directed staff to toilet R31 every 2 hours.

R31's TENA/SCA Bladder Assessment dated 8/12/14, indicated R31 was frequently incontinent of bladder and received every 2 hour toileting assistance during the day and at 2:00 a.m. during the night. The bladder assessment also indicated staff would continue to provide R31 toileting assistance every two hours during the day and at 2:00 a.m. at night.

R31's Skin Risk Assessment dated 10/18/14, identified R31 was at moderate risk for pressure ulcers due to mobility and self care deficits, dementia and bowel and bladder incontinence. The skin assessment indicated R31 required a toileting schedule with twice daily and as needed peri cares (cleaning of the genital and rectal areas).

On 10/22/14, from 7:03 a.m. until 9:48 a.m. R31 was continuously observed seated in a wheelchair at a table in the common area without a change in position / toileting assistance.

On 10/22/14, at 9:48 a.m. nursing assistant (NA)-B stated R31 was to be toileted every two

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hours, but she had not done so yet that morning. NA-B was observed to bring R31 to her bathroom and assist her onto the toilet. R31's incontinent brief was observed saturated with urine and had a strong ammonia odor. R31's right buttock was observed to have a raised welt approximately 1 1/2 inches long by 1/8 inch wide. NA-B stated the welt was not there previously and it looked like it was caused by a wrinkle in R31's brief. NA-B stated it was difficult to get everyone toileted on time in the mornings, as it was very busy. R31 did not urinate while on the toilet. NA-B was observed to provide R31 peri cares, apply a new incontinent brief and assist R31 back to her wheelchair.

On 10/22/14, at 2:29 p.m. NA-B stated she did not get R31 up for the day but toileting times were documented on care sheets carried by the NAs. NA-B indicated the care sheet was already given to NA-F who was working the next shift. NA-F stated the care sheet indicated R31 was incontinent at 5:10 a.m. and had also voided upon rising. NA-F stated the time R31 rose for the day was not documented on the care sheet but NA-E may have gotten R31 up for the day.

On 10/22/14, at 2:57 p.m. NA-E stated R31 was already up for the day when she arrived to work at 6:00 a.m.

On 10/23/14, at 9:03 a.m. NA-A stated on 10/22/14, R31 was already up in her wheelchair when the day shift came to work at 6:00 a.m. and confirmed she had not toileted R31 during the morning of 10/22/14.

On 10/23/2014, at 10:39 a.m. registered nurse (RN)-A stated she had contacted the night shift

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F 315	Continued From page 11 NA, NA-G, who indicated R31 had gotten up at approximately 5:45 a.m. on 10/22/14. RN-A confirmed R31 should have been toileted every two hours as directed by her care plan. On 10/23/2014, at 10:44 a.m. the director of nursing (DON) confirmed R31 should have been toileted every two hours as directed by her care plan. R4 was not provided toileting assistance for two hours and forty minutes on 10/22/14. R4's annual MDS dated 5/30/14, indicated R4 had dementia, severely impaired daily decision making skills and was frequently incontinent of bladder. R4's The Urinary Incontinence Care Area Assessment (CAA) dated 6/3/14, indicated R4 required extensive assistance for toileting to manage frequent bladder incontinence due to a cognitive deficit. The CAA indicated R4 was on an every two hour toileting schedule during the day. R4's quarterly MDS dated 8/29/14, indicated R4 was always incontinent of bladder. R4's care plan edited 9/16/14, directed staff to toilet R4 every two hours during the day. R4's The bladder assessment dated 10/1/14, indicated R4 was frequently incontinent of bladder and indicated staff would continue to toilet R4 every two hours during the day. On 10/22/14, during continuous observations from 7:08 a.m. until 9:48 a.m. the following was	F 315		

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observed:
-at 7:08 a.m. NA-A was observed providing R4 morning cares.
-at 7:15 a.m. R4's brief was noted to be wet. NA-A wanted to change the brief, however R4 stated, "don't make me damn mad."
-at 7:20 a.m. NA-A and NA-E were observed to provide incontinence cares and apply a clean incontinent brief.
-at 7:25 a.m. transferred R4 into a wheelchair.
-at 9:48 a.m. R4 was observed to remain up in the wheelchair.

On 10/22/14, at 10:50 a.m. R4 was observed seated in the wheelchair in front of the TV.

On 10/22/14, at 10:55 a.m. NA-A stated NA-D helped her put R4 on the toilet at 10:00 a.m. NA-A stated R4 was incontinent of urine. NA-A confirmed R4 was on an every two hour toileting schedule. NA-A stated if she was busy with another resident at the time R4's two hour time frame was up, as soon as she was finished she would get help and transfer R4 to the toilet. NA-A further stated it did not have to be at exactly 2 hours, that it might be 15 minutes before or 15 minutes after the two hour time frame. NA-A verified R4 received his last brief change at 7:20 a.m. (2 hours and 40 minutes later).

At 12:34 p.m. NA-D confirmed she assisted NA-A assist R4 to the toilet at 10:00 a.m. NA-D stated sometimes the NAs were late with toileting residents especially if they all wanted to go to the bathroom at the same time.

On 10/23/14, at 9:56 a.m. RN-A confirmed R4's care plan indicated R4 was to be toileted every two hours during the day. RN-A verified R4's care

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F 315	Continued From page 13 plan was not followed as directed. The Incontinence Management policy updated 2/12, indicated an individualized program would be developed to promote the highest level of continence for each resident.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a left knee brace according to the assessed need for 1 of 1 resident (R30) in order to minimize the risk of falls. Findings include: R30's annual Minimum Data Set (MDS) dated 6/6/14, indicated R30 had intact cognition. R30's The Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 6/10/14, indicated R30 required limited assistance with transfers and supervision with ambulation in her room and fall precautions were in place. R30's The FALL CAA dated 6/10/14, indicated R30 was at risk for falls	F 323	R30 will wear her leg brace daily per her plan of care. Day nurse will ensure resident puts it on correctly. Evening nurse will ensure resident takes it off nightly. DON/designee will audit all residents initially to ensure they are wearing any splints/braces appropriately. Staff will be educated on braces/splints at monthly staff meeting on November 20th. DON/designeewill perform monthly audits to ensure braces/splints are worn per plan of care. Audits will be reviewed quarterly at Quality Council, starting on November 26th, 2014.	11/30/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	10/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE CARE COMMUNITY	**201 9TH STREET WEST ADA, MN 56510**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 14 and wore a left leg brace daily. R30's quarterly MDS dated 9/6/14, indicated R30 was cognitively intact and required limited assistance with transfers and ambulation in her room. R30's care plan edited on 10/2/14, indicated R30 was diagnosed with a history of left hip and knee replacement and had an abnormal gait. The care plan further indicated R30 was at risk for falling related to left leg pain and a balance deficit and directed a left lower extremity brace be applied for support during transfers and ambulation. The care plan indicate R30 applied the brace daily. On 10/20/14, at 5:50 p.m. R30 was not observed to have her left knee brace on. R30 stated she had a bad knee, however, said the brace went missing on her bath day about two weeks ago and she needed to get it back. R30 stated she thought she had mentioned it to one of the nurses that she did not have her brace. On 10/21/14, at 1:30 p.m. R30 did not have her left knee brace on. R30 stated she thought the brace had been left in the tub room. On 10/22/14, at 12:45 p.m. R30 did not have her left knee brace on. R30 stated she thought the leg brace had been left in the tub room. On 10/22/14, at 12:49 p.m. nursing assistant (NA)-B stated on Monday R30 did not have her left knee brace on. NA-B instructed R30 to ask the bath aide (NA)-C about the brace. At 1:00 p.m. NA-C stated R30s left knee brace had been worn under her pants and caused a	F 323		

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F 323	Continued From page 15 sore. NA-C stated the nurse had them take the brace off and directed R30 not wear it awhile so the sore could heal. NA-C stated last week the sore was still healing and that this week R30s skin looked good. On 10/23/14, at 9:05 a.m. registered nurse (RN)-A stated she heard yesterday R30's leg brace was gone. RN-A stated a couple of weeks ago on 10/8/14, R30 had put the brace on wrong under her pants which caused a slightly reddened area. RN-A stated normally R30 wore the brace over her pants. RN-A stated she just wanted R30 not to wear the brace for that day. RN-A stated she must not have communicated that information clearly. RN-A stated she should have documented that she wanted the brace left off for just the day. RN-A confirmed R30' care plan indicated the left knee brace was to be worn daily. RN-A verified the care plan was not followed. On 10/23/14, at 9:30 a.m. RN-A stated staff were unable to find the left knee brace in the tub room and told R30 they would look in laundry for it. At 11:30 a.m. RN-A stated the facility did not have a policy which addressed the use of the left knee brace.	F 323		

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	245502	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**10/22/2014**

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BENEDICTINE CARE COMMUNITY	**201 9TH STREET WEST** **ADA, MN 56510**

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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Benedictine Care Community 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The facility was surveyed as two buildings: Benedictine Care Community is a 1-story building without a basement. The building was constructed in 2000 and was determined to be of Type II(222) construction. The building is separated from the Hospital Building with a 2-hour fire barrier and the nursing home is divided into 3 smoke compartments with 1-hour fire barriers. In 2013 a chapel/ assisted living building was constructed to the north of the care center, is 1-story, no basement and Type V (111) construction. The buildings are fully sprinkler protected with quick response sprinklers in accordance with NFPA 13 Standard for the Installation of Automatic Sprinklers 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Other hazardous areas have automatic fire detection that are on the fire alarm system in	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**10/22/2014**

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K 000	Continued From page 1 accordance with the Minnesota State Fire Code 2007 edition. The sleeping rooms have single station smoke detectors that annunciate outside the room and at the nurse's station in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm system has automatic fire department notification. The facility has a capacity of 49 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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	245502	A. BUILDING **02 - CHAPEL** B. WING _____	**10/22/2014**

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BENEDICTINE CARE COMMUNITY	**201 9TH STREET WEST ADA, MN 56510**

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K 000	INITIAL COMMENTS FIRE SAFETY 02 Chapel Building A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Benedictine Care Community 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. The facility was surveyed as two buildings: Benedictine Care Community is a 1-story building without a basement. The building was constructed in 2000 and was determined to be of Type II(222) construction. The building is separated from the Hospital Building with a 2-hour fire barrier and the nursing home is divided into 3 smoke compartments with 1-hour fire barriers. In 2013 a chapel/ assisted living building was constructed to the north of the care center, is 1-story, no basement and Type V (111) construction. The buildings are fully sprinkler protected with quick response sprinklers in accordance with NFPA 13 Standard for the Installation of Automatic Sprinklers 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Other hazardous areas have automatic fire detection that are on the fire alarm system in	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **02 - CHAPEL** B. WING _____	**10/22/2014**

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