

Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7013 2250 0001 6357 1799

July 22, 2015

Mr. Andrew Opsahl, Administrator Benedictine Health Center 935 Kenwood Avenue Duluth, Minnesota 55811

Subject: Benedictine Health Center - IDR CMS Certification Number (CCN): 245236 Project Number S5236026

Dear Mr. Opsahl:

This is in response to your letter of July 13, 2015, in regard to your request of an informal dispute resolution (IDR) for the federal deficiency at tag F463 issued pursuant to the survey event PMBM11, completed on June 25, 2015.

The information presented with your letter, the CMS 2567 dated June 25, 2015 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F463 S/S D 42 CFR § 483.70 Resident Call System: all residents when in their room, toilet or bathing area will have a means to directly contact a caregiver.

Summary of the facility's reason for IDR of this tag.

The facility disputed the findings related to the lack of a resident call system in the two identified resident rooms. The facility contends the resident rooms identified were either assessed to be unsafe/unable to use a call system or was not a resident room. The facility submitted information which revealed the resident identified had cognitive impairment and suicidal ideation with the call cord, therefore, was assessed to be unsafe with the call system. The facility floor plan also revealed the second identified room in the deficient practice was a nurse station and did not require a call system.

This in not a valid example of a deficient practice under this regulation and will be removed from the Statement of Deficiencies.

The revised Statement of Deficiencies is attached.

Benedictine Health Center July 22, 2015 Page 2

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Burkman

Lyla Burkman, Unit Supervisor Licensing and Certification Program Health Regulation Division Telephone: 218-308-2104 Fax: 218-308-2122

cc: Office of Ombudsman for Long-Term Care Pam Kerssen, Assistant Program Manager Licensing and Certification File Chris Campbell, Duluth District Office Unit Supervisor

Informal Dispute Resolution

ND PLAN OF COHRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245236 B. WING 06/25/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BENEDICTINE HEALTH CENTER 935 KENWOOD AVENUE DULUTH, MN 55811 DULUTH, MN 55811			& MEDICAID SERVICES	T			APPROVE . 0938-039
NAME OF PROVIDER OR SUPPLIER DU2/20/2015 BENEDICTINE HEALTH CENTER STREET ADDRESS, CITY, STATE, ZP CODE 040 ID PRETX TWC ISUMMARY STATEMENT OF DEFICIENCIES INVESTIGATION FOR THE APERCEDENT FULL REGULATIONY OF LSC DENTEYING INFORMATION DU 041 ID PRETX TWC ISUMMARY STATEMENT OF DEFICIENCIES INVESTIGATION FOR DEFICIENCIES INVESTIGATION FOR THE APERCEDENT TWC DU PRETX IECON CONTENTS CONTINUES TO THE APPROPRIATE DEFICIENCY OF 152 DESTIGATION The facility splan of correction (POC) will serve as your allegation of compliance upon tho Department's acceptance. Your signature at the bottom of the first page of the GMS 2567 form will be used as verification of compliance with the regulations has been attained in accordance with your verification of campliance suff the regulations has been attained in accordance with your verification, and determines that drug accurate reconciliation, and determines that drug accurate reconciliation, and determines that drug accurate reconciliation, and determines that drug appropriate accessory and cautionary instructions, and the expiration date when applicable. F 431 F 431 7/23/15 Drugs and biologicals used in the facility must be labeled in accordance with state and Fedoral laws, the facility must provide separately locked, Intel Worte	AND PLAN (TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
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The facility's plan of correction (POC) will sorve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the GMS-2567 form will be used as verification of compliance with the revisit of your facility may be conducted for validate that substantial compliance with the revisit of your recification. F 431 F 431 F 431 Upon receipt of an acceptable POC an on-site revisit of your schiftcation. F 431 F 431 SS-D LABEL/STORE DRUGS & BIOLOGICALS F 431 F 431 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records are in order and that an account of all controlled drugs is maintained and periodically records are in order and that an account of all controlled drugs is maintained and periodically records are in order and that an account of all controlled drugs is maintained and periodically records are in order and that an account of all controlled drugs is maintained and periodically records are in order and that an account of all controlled drugs is maintained and periodically records are in order and the expiration date when applicable. F 431 Imaccrate recordination; and clements upper proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, COMMON DIRECTORS OF INDUCENSUPLIER REPHESENTATIVES SIGNATURE THE THE CONTOR	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETIO DATE
as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2657 form will be used as verification of compliance. Image: CMS-2657 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained th accordance with your verification. F 431 7/23/15 F 431 483.60(b), (d), (e) DRUG RECORDS LABEL/STORE DRUGS & BIOLOGICALS F 431 7/23/15 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records are in order and that an account of all controlled drugs is sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. F 431 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and caltionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. Image: Most and the separately locked, CMIONY DIRECTORS ON PROVIDERSUPPLIER REPRESENTATIVE'S SIGNATURE TILE X00 DATE	F 000	INITIAL COMMENT	rs .	F 00	0		
ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	SS=D	as your allegation of Department's accept bottom of the first p be used as verificat Upon receipt of an a revisit of your facility validate that substa regulations has bee your verification. 483.60(b), (d), (e) D LABEL/STORE DRI The facility must err a licensed pharmac of records of receipt controlled drugs in s accurate reconciliati records are in order controlled drugs is r reconciled. Drugs and biological labeled in accordance professional principt appropriate accesso instructions, and the applicable. In accordance with S facility must store al locked compartment controls, and permit	of compliance upon the bance. Your signature at the age of the CMS-2567 form will ion of compliance. acceptable POC an on-site y may be conducted to ntial compliance with the mattained in accordance with PRUG RECORDS. UGS & BIOLOGICALS apploy or obtain the services of ist who establishes a system t and disposition of all sufficient detail to enable an ion; and determines that drug and that an account of all maintained and periodically Is used in the facility must be ce with currently accepted es, and include the bry and cautionary expiration date when State and Federal laws, the I drugs and biologicals in ts under proper temperature only authorized personnel to	F 43			7/23/15
	3ORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN/	ATURE	TITLE		

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.

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

STATEMEN	RS FOR MEDICARE T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3)	<u>VO. 0938-039</u> DATE SURVEY		
		BERTI IONTION NONBER.	A. BUILDIN	NG		COMPLETED		
NAME OF	PROVIDER OR SUPPLIER	245236	B. WING			06/25/2015		
				STREET ADDRESS, CITY, STATE, 935 KENWOOD AVENUE	ZIP CODE			
BENEDI	CTINE HEALTH CENT	ER `		DULUTH, MN 55811				
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN O	FCORRECTION	(¥5)		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETIO DATE		
F 431	Continued From pa	ge 1	F 43	81				
	permanently affixed	compartments for storage of	1 10					
	controlled drugs list	ed in Schedule II of the Ig Abuse Prevention and						
	Control Act of 1976	and other drugs subject to						
	abuse, except wher	n the facility uses single unit						
	quantity stored is m	oution systems in which the inimal and a missing dose can						
	be readily detected.							
	by:	IT is not met as evidenced						
	Based on observati	on, interview and document						
	review, the facility fa	ailed to ensure expired In to manage diabetes) were						
	removed from media	cation carts and not	A. a					
	administered for 3 o	f 3 residents (R51.R23.						
	R173) reviewed for	medication storage.						
	Findings includes							
	Findings include:							
	nurse (LPN)-C the F	o.m. with licensed practical led hall medication cart on						
	third floor was obser	ved to have a vial of Novolog						
	insulin for R51 with a	an expiration date of 6/19/15. vation LPN-C verified the						
	insulin was expired a	and R51 had been						
	administered insulin expiration date.	from the vial past the						
	expiration date.							
	On 6/25/15, at 2:55 p	o.m. with LPN-C the Green						
	hall medication cart o	on third floor was observed to						
	had been expired. R	vith insulin on the cart that 23 had a multidose vial of						
	Novolin N insulin dat	ed 5/25/15, as the date it						



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July 22, 2015

Mr. Andrew Opsahl, Administrator Benedictine Health Center 935 Kenwood Avenue Duluth, Minnesota 55811

Subject: Benedictine Health Center - IDR CMS Certification Number (CCN) 245236 Project Number S5236026

Dear Mr. Opsahl:

This is in response to your letter received on July 13, 2015, in regard to your request for an informal dispute resolution (IDR) for the federal deficiency at tag F463 where corresponding correction orders were issued pursuant to the survey completed on June 25, 2015.

The information presented with your letter, the CMS 2567 and State Form dated June 25, 2015, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of Licensing and Certification staff have been carefully considered and the following determination has been made:

4658.4635 A (3010): Resident Call System: All residents when in their room, toilet or bathing area will have a means to directly contact a caregiver.

Refer to summary outlined in the MDH letter dated July 22, 2015 addressing the IDR for federal deficiencies.

- This is not a valid correction order and will be removed from the State Form.
- The revised State Form is attached.

This concludes the Minnesota Department of Health informal dispute resolution process where corresponding correction orders were issued.

Benedictine Health Center July 22, 2015 Page 2

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

Sincerely,

, fa Burkman

Lyla Burkman, Unit Supervisor Licensing and Certification Program Health Regulation Division Telephone: 218-308-2104 Fax: 218-308-2122

cc: Office of Ombudsman for Long-Term Care Pam Kerssen, Assistant Program Manager Licensing and Certification File Chris Campbell, Duluth District Office Unit Supervisor

Informal Dispute Resolution

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201010101010

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Minneso	ota Department of He	ealth				APPROVED
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
-						
<i>,</i>		00861	B. WING		06/25/2015	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BENEDI		EK	VOOD AVEN MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of t lack of compliance. re-inspection with a result in the assess that was violated du corrected. You may request a l that may result from orders provided that the Department with	nether a violation has been				
Ainnesota Da	this Department's st and the following co When corrections a date, make a copy c original to the Minne	S: agh 6/25/2015, surveyors of aff visited the above provider rrection orders are issued. re completed, please sign and of these orders and return the esota Department of Health, ivision, Licensing and		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned to Minnesota state statutes/rules for N Homes.	ftware.	

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

TITLE

(X6) DATE 07/13/15

6899

ND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00861	B. WING		06/2	06/25/2015	
IAME OF I	PROVIDER OR SUPPLIEF	R STREET A	DDRESS, CITY,	STATE, ZIP CODE			
BENEDIC	CTINE HEALTH CEN	IER	WOOD AVEN	IUE			
		DULUTH	, MN 55811	· · · · · · · · · · · · · · · · · · ·			
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2 000	Continued From p	age 1	2 000				
	Certification Progr Bemidji, MN 5660	am; 705 5th St. N.W., Suite A, 1		The assigned tag number appr far left column entitled "ID Pre The state statute/rule number corresponding text of the state out of compliance is listed in th "Summary Statement of Defici column and replaces the "To C portion of the correction order. column also includes the find are in violation of the state stat statement, "This Rule is not me evidenced by." Following the findings are the Suggested Me Correction and the Time Period Correction. PLEASE DISREGARD THE HI THE FOURTH COLUMN WHI STATES, "PROVIDER'S PLAN CORRECTION." THIS APPLIE FEDERAL DEFICIENCIES ON WILL APPEAR ON EACH PAGE THERE IS NO REQUIREMENT SUBMIT A PLAN OF CORRECT VIOLATIONS OF MINNESOTA STATUTES/RULES.	fix Tag." and the statute/rule e encies" omply" This ngs which ute after the et as surveyors thod of d For EADING OF CH OF S TO LY. THIS E. T TO TION FOR		
2 302	MN State Statute 1 or related disorder	44.6503 Alzheimer's disease train	2 302	₩EQUELE***			
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144						
	Alzheimer's disease or related	lity serves persons with disorders, whether in a eral unit, the facility's direct					

PMBM11

If continuation sheet 2 of 4

Minneso	ota Department of He	ealth			FORM	IAPPROVED
STATEMEI AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00861	B. WING		06/	25/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	1 00/	20/2013
BENEDI	CTINE HEALTH CENT	En	NOOD AVEN MN 55811	NUE		
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2 302	care. (b) Areas of require (1) an explanation of related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic training program, the trained, the frequent topics covered. (d) The facility shall this section. This MN Requirement by: Based on interview facility failed to ensu- in a written or electronic facility staff training dementia/Alzheiment frequency of training	rs must be trained in dementia d training include: of Alzheimer's disease and activities of daily living; with challenging behaviors; skills. provide to consumers in form a description of the e categories of employees cy of training, and the basic document compliance with ent is not met as evidenced and document review, the are consumers were provided onic form, a description of for the care of residents with 's, categories of staff trained, g and topics covered in the e potential to affect all ity, and resident	2 302		· · · · · · · · · · · · · · · · · · ·	
	Findings include:					
	director of nursing, (required to receive t partment of Health	ximately 2:00 p.m., the facility DON) stated staff were raining for the care of				

STATE FORM

6899

PMBM11

If continuation sheet 3 of 4

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00861	B. WING		06/25/2015
IAME OF PRO	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
BENEDICT	INE HEALTH CEN		IWOOD AVENU I, MN 55811	JE	
(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 APPRO DEFICIENCY)	LD BE COMPL
re u d tr n u A n a c s t c c e l S a c s t c c l T T	pon hire and ong escribe how cons aining, the DON p ewsletter from De pcoming mandato lzheimer's Diseas ewsletter was left nyone could read f the facility's polic ated the facility p onsumers upon re ectronic document UGGESTED ME dministrator or de formation describ ategories of emple equency of the tra- designee could on sure compliance	rentia/Alzheimer's disease bing. However, when asked to umers were informed of staff provided a copy of a staff ecember 2014, that listed an ory training related to se. According to the DON, this throughout the facility and it. The DON provided a copy cy on dementia training which olicy was available to equest. No other written or nt was provided. THOD OF CORRECTION: The signee could provide the ing the staff training program, byees trained and the aining, as required. The DON develop an auditing system to			

STATE FORM

6899

PMBM11

If continuation sheet 4 of 4

	MDH SENDER: COMPLETE THIS SECTION	L&C 3201
	 Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 	A. Signature X. Charles M. Mala Addressee B. Received by (Printed Name) C. Date of Delivery Charles M. Wollact 7-27-15
. ,	1. Article Addressed to:	D. Is delivery address different from item 1? ☐ Yes If YES, enter delivery address below: ☐ No
	Mr. Andrew Opsahl, Administrator Benedictine Health Center 935 Kenwood Ave.	PLEASE DATE
	Duluth, MN 55811	Service Type S
	7013 2250 0001 6357 179	4. Restricted Delivery? (Extra Fee) \Box Yes $\mathcal{T} \mathcal{D} \mathcal{R}$ ML/Please return within 5 days

DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: PMBM
	PART I -	TO BE COMPL	LETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00861
1. MEDICARE/MEDICAID PROVID (L1) 245236		3. NAME AND AD (L3) BENEDICT	INE HEALTH	CENTER	ł	4. TYPE OF ACTION: <u>7 (</u> L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID N (L2) 819240500	NO.	(L4) 935 KENWOOD AVENUE (L5) DULUTH, MN			(L6) 55811	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 08/12 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	3/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/30
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:		1
From (a):		X A. In Complian			And/Or Approved Waivers Of	The Following Requirements:
To (b):			equirements e Based On:		2. Technical Personnel	
12.Total Facility Beds	96 (L18)		cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	 7. Medical Director NF)8. Patient Room Size 9. Beds/Room
13. Total Certified Beds	96 (L17)		pliance with Prog ents and/or Appli		* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF 96	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	BLE SHOW LTC CA	NCELLATION I	DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	
<u>Lyla Burkman, Unit S</u>	upervisor	1	0/13/2015	(L19)	Mark Meath,	, Enforcement Specialist 10/13/2015 (L20)
PA	RT II - TO BE	COMPLETED E	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	TATE AGENCY
 DETERMINATION OF ELIGIBII <u>X</u> 1. Facility is Eligible to F 			PLIANCE WITH ITS ACT:	I CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e .
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	. LTC AGREEN	4ENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION 11/17/1980	BEGINNINC	J DATE	ENDING DA	ГЕ	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	OTHER
	A. Suspension	n of Admissions:	(1.4.4)		04-Other Reason for Withdrawal	07-Provider Status Change 00-Active
(L27)	B. Rescind Su	spension Date:	(L44)			of neuve
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE		
	(L32)	07/29/2015		(L33)	DETERMINATION APP	ROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24 5236

Benedictine Health Center was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on June 25, 2015. On August 13, 2014, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on October 5, 2015, The Department of Public Safety completed a PCR. Based on the PCR, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on June 25, 2015 and the FMS survey completed July 15, 2015, effective, August 17, 2015.

As a result of the revisit findings, this Department recommended to the CMS Region V office the following action related to the remedy imposed in CMS letter of July 30, 2015,

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions(DPNA), effective September 25, 2015, be rescinded.

Since DPNA did not go into effect, the facility would not be subject to a two year loss of NATCEP, beginning September 25, 2015.

Refer to the CMS-2567b for both health and life safety code FMS.

Effective August 17, 2015, the facility is certified for 96 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 245236

October 13, 2015

Mr. Brian Pattock, Administrator Benedictine Health Center 935 Kenwood Avenue Duluth, Minnesota 55811

Dear Mr. Pattock:

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 August 17, 2015 the above facility is certified for:

96 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 96 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 letter.

Sincerely,

Mark meeth

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



Protecting, Maintaining and Improving the Health of Minnesotans

October 13, 2015

Mr. Brian Pattock, Administrator Benedictine Health Center 935 Kenwood Avenue Duluth, Minnesota 55811

RE: Project Number S5236026, F5236024

Dear Mr. Pattock:

On June 30, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 25, 2015. 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 July 15, 2015, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS), completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies at the time of the FMS were 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 July 30, 2015, CMS forwarded the results of the FMS and notified you that your facility was not in substantial compliance with the Federal requirements for nursing homes participation in the Medicare and Medicaid programs and that they were imposing the following enforcement remedy:

• Mandatory denial of payment for new Medicare and Medicaid admissions, September 25, 2015 (42 CFR 488.417(b)).

Also, the CMS Region V Office notified you in their letter of July 30, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 25, 2015.

On August 13, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 5, 2015 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 June 25, 2015 and a Federal Monitoring Survey (FMS) completed on July 15, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 17, 2015.

Benedictine Health Center October 13, 2015 Page 2

Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 25, 2015 and FMS completed on July 15, 2015, effective August 17, 2015.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedy outlined in the CMS letter of July 30, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 25, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective September 25, 2015 is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective September 25, 2015 is to be rescinded.

In the CMS letter of July 30, 2015 CMS advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 25, 2015 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 25, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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 letter.

Sincerely,

Mark meath

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

Enclosure(s)

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 245236	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/13/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
BENEDICTINE HEALTH CENTER			935 KENWOOD AVENUE DULUTH, MN 55811	

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	()	(5)	Date
ID Prefix	F0431	C	Correction Completed 7/23/2015	ID Prefix		Correction Completed	ID Prefix			Correction Completed
	483.60(b), (d), (e)			Reg. # LSC			Reg. # LSC			
		-	Correction			Correction Completed				Correction Completed
ID Prefix			in pierce a	ID Prefix		Completed	ID Prefix			
Reg. # LSC				Reg. # LSC			Reg. # LSC			
ID Prefix		C	Correction Completed	ID Prefix		Correction Completed	ID Prefix			Correction Completed
Reg. # LSC							Reg. #			
Reg. #			Correction Completed			Correction Completed				Correction Completed
ID Prefix		C (Correction Completed	ID Prefix		Correction Completed	ID Prefix			Correction Completed
Reviewed B State Agen	ID	iewed I /mm	Зу	Date: 10/13/2015	Signature of Sur 2803	-			Date: 08/1	13/2015
-	-	iewed E	Зу	Date:	Signature of Sur	veyor:			Date:	
Followup t	o Survey Complet 6/25/201				Check for any Uncor Uncorrected Defic				YES	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 245236	A. Building	° 01 - MAIN BLUU DING 01			
Name of Facility		Street Address, City, State, Zip Code			
BENEDICTINE HEALTH CENTER		935 KENWOOD AVENUE DULUTH, MN 55811			

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 07/15/2015	ID Prefix		Correction Completed 08/06/2015		ID Prefix			Correction Completed 07/28/2015
0	NFPA 101		0	NFPA 101			Reg. #	NFPA 101		
LSC	K0018		LSC	K0022			LSC	K0025		_
Reg. #	NFPA 101 K0027	Correction Completed 07/28/2015	Reg. #	NFPA 101 K0038	Correction Completed 08/10/2015		Reg. #	NFPA 101 K0045		Correction Completed 08/17/2015
-	NFPA 101 K0050	Correction Completed 07/16/2015	Reg. #	NFPA 101 K0054	Correction Completed 08/05/2015		Reg. #	NFPA 101 K0056		Correction Completed 08/13/2015
-	NFPA 101 K0062	Correction Completed 08/06/2015	Reg. #	NFPA 101 K0143	Correction Completed 07/15/2015		Reg. #	NFPA 101 K0144		Correction Completed 08/15/2015
Reg. #	NFPA 101 K0147	Correction Completed 08/10/2015	Reg. #				Reg. #			
Reviewed I	Ву	Reviewed By	Date:	Signature	of Surveyor:				Date:	
State Agency GS/mm		10/13/20	15	27200				10/0	5/2015	
Reviewed I CMS RO	Ву	Reviewed By	Date:	Signature	of Surveyor:				Date:	
Followup t		mpleted on: 5/2015			VUncorrected Defind Deficiencies (CM				YES	NO

DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDI	CAID SERVICES
					AND TRANSMITTAL		ID: PMBM
	PART I -	TO BE COMPI	LETED BY 1	THE STAT	FE SURVEY AGENCY	1	Facility ID: 00861
1. MEDICARE/MEDICAID PROVIDER (L1) 245236	NO.	3. NAME AND AL (L3) BENEDICT			1	4. TYPE OF ACTI 1. Initial	ON: <u>2 (</u> L8) 2. Recertification
2.STATE VENDOR OR MEDICAID NO (L2) 819240500).	(L4) 935 KENWO (L5) DULUTH, N		E	(L6) 55811	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OV (L9)	WNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEC 05 HHA	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Aft	9. Other er Complaint
6. DATE OF SURVEY 06/25/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TIC	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/III 12 RHC	14 CORF 0 15 ASC 16 HOSPICE	FISCAL YEAR END 06/30	ING DATE: (L35)
2 AOA 3 Other							
11. LTC PERIOD OF CERTIFICATION		10.THE FACILITY		AS:			
From (a):		A. In Complia Program R	nce With equirements		And/Or Approved Waivers Of 2. Technical Personnel		
To (b):			e Based On:		3. 24 Hour RN	7. Medical D	
12.Total Facility Beds	96 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code	NF)8. Patient Roo 9. Beds/Room	
13.Total Certified Beds	96 (L17)	X B. Not in Com Requirement	npliance with Prop ents and/or Appli		* Code: B *	(L12)	
14. LTC CERTIFIED BED BREAKDOW	'N				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
96 (L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Susan Frericks, HPR S	WS	0	07/20/2015	(L19)	Mark Meath	, Enforcement Spec	07/28/2015 (L20)
PAR	Г II - TO BE	COMPLETED H	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY	
19. DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to Pan			IPLIANCE WITI HTS ACT:	H CIVIL	 Statement of Fina Ownership/Contre Both of the Above 	ol Interest Disclosure Stm	
2. Facility is not Eligible	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION	BEGINNINC	G DATE	ENDING DA	TE	VOLUNTARY 00	INVOLU	INTARY
11/17/1980					01-Merger, Closure	05-Fail to	Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	
	A. Suspension	n of Admissions:	(7.44)		04-Other Reason for windrawar	07-Provi 00-Activ	der Status Change
(L27)	B. Rescind Su	uspension Date:	(L44)			00-Activ	c
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	L DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 1614

June 30, 2015

Mr. Andrew Opsahl, Administrator Benedictine Health Center 935 Kenwood Avenue Duluth, Minnesota 55811

RE: Project Number S5236026

Dear Mr. Opsahl:

On June 25, 2015, 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.

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:

Chris Campbell, Unit Supervisor Duluth Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Duluth Technology Building 11 East Superior Street, Suite #290 Duluth, Minnesota 55802 Email: chris.campbell@state.mn.us

Phone: (218) 302-6151 Fax: (218) 723-2359

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 August 4, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

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.

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

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 Health Center June 30, 2015 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 September 25, 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

Benedictine Health Center June 30, 2015 Page 5

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 December 25, 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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 Health Center June 30, 2015 Page 6 Feel free to contact me if you have questions related to this letter.

Sincerely,

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

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

Enclosure

cc: Licensing and Certification File

			ten er an			a a D		00/20/2045
DEPART	MENT OF HEALTH	AND HUMAN SERVICES	2			ξ. Ρ		06/30/2015 APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			; RJRC 0-6/2015	0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		UL 15 2015			E SURVEY PLETED
		245236	B. WING		inaestea Department of Health Bennicht		06/	25/2015
NAME OF F	PROVIDER OR SUPPLIER		1.54-		EET ADDRESS, CITY, STATE, ZI KENWOOD AVENUE	PCODE		
BENEDIC	CTINE HEALTH CENT	ER			_UTH, MN 55811	(* · ·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	S	FC	000				
	as your allegation o Department's accep	f correction (POC) will serve f compliance upon the otance. Your signature at the age of the CMS-2567 form will ion of compliance.						
F 431 SS=D	revisit of your facility validate that substa regulations has bee your verification. 483.60(b), (d), (e) D	acceptable POC an on-site y may be conducted to ntial compliance with the n attained in accordance with NRUG RECORDS, UGS & BIOLOGICALS	F 4	31				
	a licensed pharmac of records of receip controlled drugs in s accurate reconciliat records are in order	ploy or obtain the services of ist who establishes a system t and disposition of all sufficient detail to enable an ion; and determines that drug and that an account of all maintained and periodically						
	labeled in accordan professional princip appropriate accesso						App	Dued
	facility must store a locked compartmen	State and Federal laws, the I drugs and biologicals in ts under proper temperature only authorized personnel to keys.						120
		ovide separately locked,						
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER BEPRESENTATIVE'S SIGN	ATURE		TITLE interim administra	ator		(X6) DATE 3-15

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.

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 245236 B. WING 06/25/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 935 KENWOOD AVENUE BENEDICTINE HEALTH CENTER **DULUTH, MN 55811** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 431 F 431 Continued From page 1 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired insulins (medication to manage diabetes) were R23 has been discharged from the removed from medication carts and not facility. administered for 3 of 3 residents (R51,R23, R173) reviewed for medication storage. The expired vials of insulin for R51 Findings include: and R173 have been discarded and replaced with new vials of insulin via the pharmacy. On 6/25/15, at 2:47 p.m. with licensed practical On 7/13/15 consulting pharmacy nurse (LPN)-C the Red hall medication cart on staff completed cart audits on all third floor was observed to have a vial of Novolog insulin for R51 with an expiration date of 6/19/15. five medication carts and will At the time of observation LPN-C verified the continue to conduct monthly audits insulin was expired and R51 had been on all carts. Any concerns identified administered insulin from the vial past the will be brought to and reviewed by expiration date. the Quality Council during the next meeting. On 6/25/15, at 2:55 p.m. with LPN-C the Green hall medication cart on third floor was observed to have two residents with insulin on the cart that had been expired. R23 had a multidose vial of Novolin N insulin dated 5/25/15, as the date it

Facility ID: 00861

PRINTED: 06/30/2015

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING 245236 B. WING 06/25/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 935 KENWOOD AVENUE BENEDICTINE HEALTH CENTER **DULUTH, MN 55811** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY** The medication storage policy has F 431 F 431 Continued From page 2 been reviewed and remains was opened, no expiration date was written on appropriate. the vial. R173 had a multidose Novolog flex pen All licensed nursing staff as well as with and expiration date of 6/4/15. LPN-C verified at the time of observation that both insulins were the trained medication expired and both R23 and R173 had been administration assistants (TMAs) administered the insulins past the expiration will be re-educated regarding the dates. policy, procedure and expectations. Pharmacy guidelines on the medication carts indicated after opening an insulin vial it was to be Medication cart audits will be discarded and not used after 28 days. conducted weekly by nursing staff on all five carts until the QA committee deems 100% On 6/25/15, at 3:09 p.m. registered nurse (RN)-C stated that the medications carts should have compliance regarding expired been inspected periodically, and at least weekly medications. for expired medications. RN-C also stated The Director of Nursing/Designee expired medications should not have been on the will be responsible for conducting carts and administered to residents. audits for compliance and reporting results of audits to the QA On 6/25/15, at 3:13 p.m. director of nursing committee. (DON) stated her expectation was that there would not be expired medications on the carts Facility will be in compliance by and residents were not to be administered expired medications. 7/23/2015. The policy Medication Storage dated 4/13, indicated drugs shall not be kept on hand after the expiration date and on a weekly basis the night nurse will check medication carts for expired medications and remove and dispose of them per disposal policy. F 463 483.70(f) RESIDENT CALL SYSTEM -F 463 ROOMS/TOILET/BATH SS=D

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

Facility ID: 00861

PRINTED: 06/30/2015

		AND HUMAN SERVICES				FORM	06/30/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` <i>'</i>		E CONSTRUCTION		SURVEY PLETED
		245236	B. WING			06/2	25/2015
NAME OF I	PROVIDER OR SUPPLIER	L			TREET ADDRESS, CITY, STATE, ZIP CODE 35 KENWOOD AVENUE		
BENEDI	CTINE HEALTH CENT	ER			ULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 463	The nurses' station resident calls throu from resident room facilities. This REQUIREMEI by: Based on observa failed to ensure cal good repair for 2 of R196) reviewed for Findings include: On 6/22/15 at 7:15 in R117's room. Th desk, but not down (NA)-E was notified was not working. Interview with R196 resident indicated t not working. The c time and did not lig Registered nurse (p.m. The RN attern and confirmed it did would notify mainted Interview with the r 6/23/15, at 11:21 a R196 call light on 6 attempts to activate cord and call button	must be equipped to receive gh a communication system s; and toilet and bathing NT is not met as evidenced tion and interview, the facility I lights were functioning and in 35 resident's (R117 and functioning call lights. p.m., the call light was tested he call light lit up by the front the hall. Nursing assistant d at that time and confirmed it 6 on 6/22/15 at 3:15 p.m. the the call light in her room was call light was activated at that ht up on the wall, or in the hall. RN)-B was notified at 3:20 npted to activate the call light d not work. She indicated she enance. maintenance manager on .m. indicated he had checked 6/22/15, and out of 15-20 e, it did not work twice. The	F	463	Request IDR for F463. The ca lights are working and care pla remain appropriate. R117 care planned not to have call light. Discussed with Supervisor.	ans	
FORM CMS-2	the call lights were	checked prior to a resident	11	Fac	cility ID: 00861 If continu	ation shee	et Page 4 of 5

CENTERS FOR MEDICARE & M	MEDICAID SERVICES			O		APPROVED 0938-0391
) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
	245236	B. WING	i		06/2	25/2015
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDICTINE HEALTH CENTER				35 KENWOOD AVENUE DULUTH, MN 55811		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
He indicated call lights routinely, if a problem v	as part of the room set up. were not checked was noted it was to be nental clip board so it could ified he had not been	F 4	463			

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

Event ID: PMBM11

Facility ID: 00861

If continuation sheet Page 5 of 5

PRINTED: 06/30/2015

	MENT OF HEALTH				36023	FOR	: 06/25/2015 A APPROVED). 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE			PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE S COMPL	
		245236		B. WING		06/2	25/2015
	ROVIDER OR SUPPLIER CTINE HEALTH CEI	NTER	935 KE	NWOOD A			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	S		K 000			
	FIRE SAFETY						
		Survey was conduct	ed by the				
	Minnesota Departm	ent of Public Safety. Benedictine Health (At the	0			
	was found in subst	antial compliance wi					
		at 42 CFR, Subpart					
ø	edition of National F	ety from Fire, and the Fire Protection Assoc	iation				
11	(NFPA) Standard 10 Chapter 19 Existing	01, Life Safety Code Health Care.	(LSC),		0		1
	building with no bas was constructed in Both buildings are of Because the original of the same type of	Center is a three sto ement. The original 1980 with an addition of type II(111) constru- I building and the ad construction allowed he facility was survey	building n in 1990. uction. Idition are I for				
	one building.						
	facility has a comple smoke detection in open to the corridor automatic fire depar	fire sprinkler protect ete fire alarm system the corridors and spa , that is monitored for tment notification. T acity of 120 beds and time of the survey.	with aces or he facility				
	The requirement at MET.	42 CFR Subpart 483	3.70(a) is				
LABORATOR	RY DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESE	NTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

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



Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7013 2250 0001 6357 1614

June 30, 2015

Mr. Andrew Opsahl, Administrator Benedictine Health Center 935 Kenwood Avenue Duluth, Minnesota 55811

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5236026

Dear Mr. Opsahl:

The above facility was surveyed on June 22, 2015 through June 25, 2015 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, Health Regulation 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.

Benedictine Health Center June 30, 2015 Page 2 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:

Chris Campbell, Unit Supervisor Duluth Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Duluth Technology Building 11 East Superior Street, Suite #290 Duluth, Minnesota 55802 Email: chris.campbell@state.mn.us

Phone: (218) 302-6151 Fax: (218) 723-2359

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 Chris Campbell the phone number or email listed above**.

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.

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

Sincerely, Mark Meath

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

Enclosure(s)

Leve 1 *.

PRINTED: 06/30/2015 FORM APPROVED

				RFC1 - UUL- 0 /3 2015		
TATEMEN	a Department of He	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SU COMPLE	RVEY TED
ND PLAN (OF CORRECTION	IDENTIFICATION NOMBER.				
		00861	B. WING	linnestoa Department of Health Benildji	06/25/	2015
NAME OF P	ROVIDER OR SUPPLIER			TATE, ZIP CODE		
RENEDIC	TINE HEALTH CENT		VOOD AVENU MN 55811	JE		
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR	JLD BE	(X5) COMPLETE DATE
TAG	REGULATORTORI			DEFICIENCY)		
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
		CORRECTION ORDER				
	1/1/10 10 this corre	n Minnesota Statute, section ection order has been issued				
	nursuant to a SUIV	ev. If, upon reinspection, it is				
	found that the defi	ciency or deficiencies cited rected, a fine for each violation				
	not corrected shall	the assessed in accordance				
	with a schedule of	fines promulgated by rule of				
		partment of Health.				
	Determination of v	whether a violation has been				
	corrected requires	s compliance with all ne rule provided at the tag				
	number and MN F	Rule number indicated below.				
	Mhon a rule cont	ains several items, failure to				
	lack of complianc	of the items will be considered e. Lack of compliance upon				
	I ro inspection with	any item of multi-part rule will				NONDC
	result in the asse	ssment of a fine even if the item during the initial inspection was				NON
	corrected.	during the transfer of				HK 1bi
		a hearing on any assessments				
	that may result fr	om non-compliance with these				
	orders provided t	hat a written request is made to				
	the Department v	vithin 15 days of receipt of a ment for non-compliance.				
	INITIAL COMME	NTS: rough 6/25/2015, surveyors of		Minnesota Department of Heal	th is	
	this Denartment	s statt visited the above provide	r	documenting the State Licensin Correction Orders using feder	ng	
	and the following	correction orders are issued.		Tag numbers have been assign	ned to	
	Mhon correction	s are completed, please sign ar by of these orders and return the	e	Minnesota state statutes/rules	for Nursing	
	original to the Mi	nnesota Department of reality,		Homes.		
	Health Regulation	n Division, Licensing and				
Minnesota		OVIDER/SUPPLIEB REPRESENTATIVE'S S	SIGNATURE	TITLE		(X6) DATE
LABORATO	DRY DIRECTOR'S	JVIDER/SUFFLICHALT RECERT, AVEOR		interim administrator	. 7-	13-15

2 612,818

TATEMEN	a Department of He of DEFICIENCIES of CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE SURVEY COMPLETED	
,		00861	B. WING		06/2	5/2015
			DRESS CITY	STATE, ZIP CODE		
	ROVIDER OR SUPPLIER	935 KEN	WOOD AVEN			
ENEDIC	TINE HEALTH CENT	ER DULUTH	MN 55811			
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	Certification Progra Bemidji, MN 56601	am; 705 5th St. N.W., Suite A,		The assigned tag number app far left column entitled "ID Pr The state statute/rule number corresponding text of the state out of compliance is listed in t "Summary Statement of Defic column and replaces the "To portion of the correction order column also includes the fine are in violation of the state sta statement, "This Rule is not n evidenced by." Following the findings are the Suggested M Correction and the Time Peric Correction. PLEASE DISREGARD THE I THE FOURTH COLUMN WH STATES, "PROVIDER'S PLA CORRECTION." THIS APPLI FEDERAL DEFICIENCIES O WILL APPEAR ON EACH PA THERE IS NO REQUIREME SUBMIT A PLAN OF CORRE VIOLATIONS OF MINNESO STATUTES/RULES.	efix Tag." and the e statute/rule he ciencies" Comply" c. This dings which atute after the net as e surveyors ethod of od For HEADING OF IICH N OF IES TO NLY. THIS GE. NT TO ECTION FOR	
2 302	MN State Statute or related disorde	144.6503 Alzheimer's disease r train	2 302			
	ALZHEIMER'S DI DISORDER TRAI MN St. Statute 14					
	Alzheimer's disease or related	cility serves persons with I disorders, whether in a neral unit, the facility's direct				

STATE FORM

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00861	B. WING		06/	25/2015
NAME OF F	OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
BENEDIC	CTINE HEALTH CENT	ED	WOOD AVENU , MN 55811	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLE ⁻ DATE
2 302	care staff and their superviso care. (b) Areas of require (1) an explanation related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electroni training program, ti trained, the frequent topics covered.	ors must be trained in dementia ed training include: of Alzheimer's disease and activities of daily living; g with challenging behaviors;	2 302			
	by: Based on interview facility failed to ens in a written or elec facility staff training dementia/Alzheime frequency of training					
	director of nursing	roximately 2:00 p.m., the facilit , (DON) stated staff were e training for the care of	У			

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Minneso	ta Department of He	ealth			·	
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00861	B. WING		06/2	5/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT	'ED	VOOD AVENU MN 55811	JE		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 302	Continued From pa	age 3	2 302			
	upon hire and ongo describe how cons training, the DON p newsletter from De upcoming mandato Alzheimer's Diseas newsletter was left anyone could read of the facility's polic stated the facility p consumers upon re electronic documen	THOD OF CORRECTION: The				
	information describ categories of empl frequency of the tra or designee could ensure compliance	signee could provide the bing the staff training program, oyees trained and the aining, as required. The DON develop an auditing system to b. R CORRECTION: Twenty-One				
23010	MN Rule 4658.463 Construction	35 A Nurse Call System; New	23010			
	communication sy from the resident a required by this pa system, if electrica connected to the e Nurse calls and er of being inactivate	n must be equipped with a stem designed to receive calls and nursing service areas art. The communication ally powered, must be emergency power supply. mergency calls must be capable of only at the points of origin. A pr must be provided where the				

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PMBM11

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _		СОМ	PLETED
		00861	B. WING		06/	25/2015
IAME OF F	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
			WOOD AVENU	JE		
SENEDIC	TINE HEALTH CENT	DULUTH	, MN 55811			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPL DATI
23010	Continued From pa	ige 4	23010			
	door is not visible f	rom the nurses' station.				
	resident's bed. Ca communication dev they are within read from a resident mu station, activate a l bedroom, and activ medication room, r room, soiled utility multi-corridor nursi	must be provided for each ll cords, buttons, or other vices must be placed where ch of each resident. A call st register at the nurses' ight outside the resident vate a duty signal in the nourishment area, clean utility room, and sterilizing room. In ng units, visible signal lights at corridor intersections.				
	by: Based on observat failed to ensure ca good repair for 2 o	s MN Requirement is not met as evidenced				
	Findings include:					
	On 6/22/15 at 7:15 p.m., the call light was te in R117's room. The call light lit up by the fr desk, but not down the hall. Nursing assista (NA)-E was notified at that time and confirm was not working.	he call light lit up by the front the hall. Nursing assistant				
	resident indicated not working. The time and did not lig Registered nurse p.m. The RN atte	6 on 6/22/15 at 3:15 p.m. the the call light in her room was call light was activated at that ght up on the wall, or in the hall (RN)-B was notified at 3:20 mpted to activate the call light id not work. She indicated she enance.				
		maintenance manager on				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00861	-		06/	/25/2015	
			I			2012010	
AME OF F	PROVIDER OR SUPPLIER		VOOD AVENU	TATE, ZIP CODE			
ENEDIC	CTINE HEALTH CENT	FR	MN 55811				
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE	
23010	Continued From pa	age 5	23010				
	6/23/15, at 11:21 a.m. indicated he had checked R196 call light on 6/22/15, and out of 15-20 attempts to activate, it did not work twice. The cord and call button were replaced. Additional interview with the maintenance						
	manager on 6/25/1 the call lights were moving into the roo He indicated call lig routinely, if a proble logged on the envir be addressed. He	with the maintenance 5, at 1:30 p.m. he indicated checked prior to a resident om as part of the room set up. ghts were not checked em was noted it was to be ronmental clip board so it could verified he had not been ight not working for R117.					
	The administrator a could review and re- related to the funct administrator, main nursing or designe report non-function could be made. The director or director audits of call lights The results of the a quality assurance of	THOD OF CORRECTION: and/or maintenance director evise policy and procedures ioning of call lights. The ntenance director, director of e could educate staff on how to ning call lights so that repairs ne adminstrator, maintenance of nursing could perform to ensure functional status. audits could be reviewed by the committee. R CORRECTION: Twenty-on					

PMBM11