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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: TN48

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00352

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245459**

2.STATE VENDOR OR MEDICAID NO.
(L2) **787477100**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY WINSTED**
(L4) **551 FOURTH STREET NORTH**
(L5) **WINSTED, MN** (L6) **55395**

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) **02/01/2011**

6. DATE OF SURVEY **05/10/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(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 :
Brenda Fischer, Unit Supervisor 05/10/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 05/20/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/26/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245459
May 20, 2016

Ms. Terry Rieck, Administrator
Benedictine Living Community Winsted
551 Fourth Street North
Winsted, Minnesota 55395-0750

Dear Ms. Rieck:

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 April 21, 2016 the above facility is certified for or recommended for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 20, 2016

Ms. Terry Rieck, Administrator
Benedictine Living Community Winsted
551 Fourth Street North
Winsted, Minnesota 55395-0750

RE: Project Number S5459026

Dear Ms. Rieck:

On April 7, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 24, 2016. 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 May 10, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 2, 2016 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 March 24, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 21, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 24, 2016, effective April 21, 2016 and therefore remedies outlined in our letter to you dated April 7, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245459 Y1	A. Building B. Wing Y2	5/10/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241	Correction	ID Prefix F0282	Correction	ID Prefix F0309	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed
LSC	04/21/2016	LSC	04/17/2016	LSC	04/21/2016
ID Prefix F0315	Correction	ID Prefix F0369	Correction	ID Prefix	Correction
Reg. # 483.25(d)	Completed	Reg. # 483.35(g)	Completed	Reg. #	Completed
LSC	04/17/2016	LSC	04/17/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 05/20/2016	SIGNATURE OF SURVEYOR 10562	DATE 05/10/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
3/24/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245459 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/2/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0027	Correction Completed 04/17/2016	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 04/17/2016	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 05/20/2016	SIGNATURE OF SURVEYOR 34764	DATE 05/02/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/23/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245459	A. Building 02 - NEW MAIN ENTRANCE B. Wing	5/2/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 04/13/2016	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
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/23/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: TN48

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00352

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245459**

2.STATE VENDOR OR MEDICAID NO.
(L2) **787477100**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY WINSTED**
(L4) **551 FOURTH STREET NORTH**
(L5) **WINSTED, MN** (L6) **55395**

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) **02/01/2011**

6. DATE OF SURVEY **03/24/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(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 :
Bruce Melchert, HFE NE II 04/18/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 04/20/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(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 04/26/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 7, 2016

Ms. Terry Rieck, Administrator
Benedictine Living Community, Winsted
551 Fourth Street North
Winsted, Minnesota 55395-0750

RE: Project Number S5459026

Dear Ms. Rieck:

On March 24, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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:

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:

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 3, 2016, 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 June 24, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal

regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 24, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

(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 A recertification survey was conducted from 3/22/16 to 3/24/2016, with surveyors from the Minnesota Department of Health. 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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a dignified rising and morning routine for 1 of 4 residents (R28) observed for activities of daily living. Findings include: R28's quarterly Minimum Data Set (MDS) dated 1/7/16, identified R28 had severe cognitive	F 241	R28 is provided with dignity at all rising routines. All residents have the potential to be affected by the same deficient practice. To ensure full understanding of St. Mary's dignity policy a mandatory in service will be conducted for all impacted personnel regarding dignity, respect and individuality for all of	4/21/16

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

Electronically Signed | 04/12/2016

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F 241	Continued From page 1 impairment, and required total dependence on staff for bed mobility, transferring, dressing, and personal hygiene. R28's plan of care dated 1/11/16, identified staff are to provide total assist with dressing and grooming. During observation on 3/24/16 at 6:59 a.m., nursing assistant (NA)-C and NA-D entered R28's room to provide personal cares. After completing personal cares, they placed an incontinent brief on R28, and put her pants on while in bed. They pulled her pants up so they were just above her the knees, but below the incontinent brief. They placed the bedding covers over R28, and left the room. When interviewed on 3/24/16, at 7:08 a.m. upon exiting R28's room, NA-C stated R28 will remain in bed at this time, and staff will assist in getting her into her wheelchair around 8:00 a.m. for breakfast. Registered nurse (RN)-E and surveyor observed R28 in bed on 3/24/16, at 8:32 a.m., covered with sheets and bed spread. RN-E removed R28's bedding, and saw R28's with her pants on, pulled up between her knees and incontinent pad, making it difficult for R28 to move in bed. RN-E stated, this should not happen, because this would be "undignified" for the resident. When interviewed on 3/24/16, at 12:33 p.m. NA-C stated staff typically leave R28's pants down below her incontinent pad, because they will check if R28 has been incontinent prior to getting her up in the chair for breakfast. Further, NA-C stated this would be done the same for any resident who was up in their wheelchair for meals	F 241	our residents on 4/21/16. This education will be covered annually and upon orientation as well to ensure on-going compliance. Education will be conducted by social service designee or designee. Clinical Manager, DON, and Administrator will conduct weekly audits for one month and monthly x 3 months to ensure dignity is provided. The Quality Council team will analyze data obtained during auditing process and determine need of on-going monitoring and/or protocol enhancements. Administrator/DON will ensure compliance of POC.	

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F 241	Continued From page 2 only. When interviewed on 3/24/16, at 2:54 p.m. director of nursing (DON) stated she would expect that resident either have their pants pulled all the way up around the waist or removed completely when in bed. It was not acceptable for residents to have their pants down below the incontinent pad and above the knees when in bed. A facility policy regarding resident dignity was requested, but none provided.	F 241		
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 ensure nutritional care plan interventions were followed for 1 of 1 residents (R13) reviewed for nutrition. Findings include: R13's annual Minimum Data Set (MDS) dated 1/9/16, indicated R13 had severe cognitive impairment and required supervision for eating. R13's care plan dated 1/27/16, identified R13 had, "Nutrition concerns ... Dementia and difficulty feeding self m/b [manifested by] need for	F 282	The care plan for R13 is currently being followed to ensure that a plate guard and non-skid mat is being provided at mealtimes. All residents have the potential to be affected by same deficient practice. Culinary and nursing staff will be educated regarding use of adaptive equipment, communication of use and accountability for following resident specific care plan approaches. Specialized care planned nutrition interventions will be evaluated for all residents and implemented as indicated.	4/17/16

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F 282	Continued From page 3 adaptive equipment and a therapeutic diet..." The care plan directed staff to, "Provide plate guard with non-skid mat, with plate- guard arch facing her. Tray set up at all meals." On 3/23/16, at 5:24 p.m. R13 was provided supper which consisted of a salami sandwich, baked beans, and cut up watermelon. R13's meal was served on a regular plate and placed on a green paper placemat in front of her. There was no plate guard or non-skid mat provided to R13 as directed by the care plan. R13 held the fork in her left hand and attempted to eat the baked beans and cut up watermelon; however, R13 spilled food off the edge of the plate as she attempted to eat. When R13 finished her meal, she had several pieces of cut up watermelon and several baked beans on the table. During interview on 3/24/16, at 12:19 p.m. culinary service director (CSD) stated R13's plate guard should be at the bottom of her plate, and a non-skid mat under R13's plate. This was an error, and the care plan was not followed. When interviewed on 3/24/16, at 3:09 p.m. occupational therapist (OT)-A stated R13 should have been provided a plate guard and a non-skid mat under her plate because R13 needed assistance with her meals mostly due to her, "Cognition and vision problems." A policy regarding resident care plans was requested, but not provided.	F 282	Audits will be conducted weekly for one month, and then monthly for three months to ensure careplanned nutrition interventions are being met. DON and/or Culinary Director or designees will conduct audits. The Quality council committee will analyze data obtained during auditing process and determine need of on-going monitoring and /or protocol enhancements. Administrator will ensure compliance of POC	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		4/21/16

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F 309	Continued From page 4 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide specific guidelines for staff to effectively provide fluid restrictions for 1 of 1 residents (R21) reviewed for dialysis. Findings include: R21's annual Minimum Data Set (MDS) dated 11/9/15, indicated R21 was cognitively intact, did not not reject any care and needed supervision while eating. The MDS identified a diagnosis of renal failure and was receiving dialysis treatments. R21's nutritional Care Area Assessment (CAA) dated 11/9/15, identified R21 was at nutritional risk due to an order for 1500 cubic centimeters (cc) of fluid per day and R21 was observed to have dry lips and mouth, related to fluid restrictions and being a hemodialysis patient. The CAA further identified that the resident may experience thirst and may be at risk for going over fluid requirements. However, the CAA did not address a plan for R21's fluid restrictions. R21's Physician Order Report signed 12/8/15, ordered 1500 cc of fluid per day with a start date of 11/17/14.	F 309	Fluid restrictions are being monitored for R74. All residents on fluid restrictions are at risk for same deficient practice The IDT has adjusted facility protocol for fluid restriction communication and documentation. The protocol is comprehensive and ensures staff compliance. Mandatory education will be conducted by culinary director and/or DON or designees on 4/21/16. Education will include protocol changes and highlight importance of compliance and reporting guidelines. When a resident receives order for fluid restriction: culinary, nursing, RD, and resident will collaborate to determine amount of fluids that can be consumed at each meal and each shift and care plan restriction totals. These totals will be communicated to all staff via the tray card system, assignments sheets and E-MAR. Culinary will note fluid restriction on diet tray card system and nursing will note fluid restriction on assignment sheets and E-MAR. Fluid intakes will be recorded daily at each meal and upon consumption of fluids throughout the day. Nursing will record all	

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F 309	Continued From page 5 R21's nutrition care plan dated 12/12/14, identified dietary was to provide R21 with a 1500 cc fluid restriction at meals and to record fluid intakes daily to assure appropriate amounts of fluid. The care plan did not identify how much fluid to provide at each meal for R21. R21's hemodialysis care plan dated 11/30/15, identified R21 went to the dialysis clinic Monday, Wednesday and Fridays. The care plan included a fluid restriction of 1500 cc/24 hours and directed the staff to remind and encourage R21 to follow restrictions as R21 is often non- compliant. In addition the care plan further directed staff to monitor and record fluid intake every shift and for the night shift to record fluid intake in the electronic medical record. The care plan did not identify how much fluid nursing should provide for each shift. During observation on 3/23/16, at 5:11 p.m. R21 was served 240 cc's of ice water, 240 cc's of juice and 240 cc's of coffee at her table setting for at total of 720 cc served to her by the dietary staff for the dinner meal. The dietary tray card on the table identified a 1500 cc fluid restriction but did not provide instruction for how much fluid should be served with each meal. On 3/24/16, at 7:03 a.m. a clear water glass with a lid and straw with approximately 360 cc's of water in it was on R21's bedside table. The cup could hold 480 cc's. Written on the lid of the glass was "max 6 cups per day." This was in addition to the 1500 cc dietary was providing for R21. On 3/24/16, at 7:58 a.m. R21 was served by dietary staff 240 cc of ice water, 240 cc of juice	F 309	fluids administered during their shift in the electronic medical record including: fluids with meals, activities, medications and supplements. Upon return from dialysis unit nursing will review the "Dialysis Communication Form", and implement all orders indicated on form as ordered by MD. The facility will also request total fluid intake while at dialysis which is on the Dialysis Communication Form. Weekly audits will be conducted for one month and then monthly for three months by Culinary Director and/or clinical managers or designees ensuring fluid restrictions total are meeting restrictions set by nephrologist/dialysis unit. Upon identification of non-compliance facility will update the Dialysis unit of non-compliance and educate resident on significance.Quality Council will review audits monthly for completion and further recommendations.	

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F 309	Continued From page 6 and 240 cc of coffee at her table setting for at total of 720 cc served to her by the dietary staff for the breakfast meal. When interviewed on 3/24/16, at 8:41 a.m. dietary aid (DA)-A stated she wasn't sure what R21's fluid restrictions were but thought they were 1200 cc a day. DA-A wasn't sure on how much fluids she was to have at each meal, but thinks it is 420 cc at each meal. She stated that R21 requests ice water for chewing,and if she requests more fluid that is provided during the meal we remind her of her fluid restrictions and then give her what she requested. When interviewed on 3/24/16, at 12:53 p.m. nursing assistant (NA)-B reported that R21 was kind of restricted with water in her room, but does not know what her restrictions were. NA-B further stated that the aids used to track fluid intake in her room, but no longer are. The nursing assistant care sheet identified R21 was on fluid restrictions, but did not identify the the fluid restriction amount or how to track fluid intake. Review of R21's Dialysis Communications Record dated 12/21/15, included direction from the dialysis unit to facility staff : " Fluid restriction 1500 cc/ daily. Please assist [R21] /c [with] fluid management. She gained 12.5 lbs. [pounds] since Friday." R21's Dialysis Communications Record dated 12/26/15, included direction from the dialysis unit to facility staff to: " ...during tx's, large amt [amount] of fluid gain over 14 lbs over holiday break (2 days)."	F 309		

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F 309	Continued From page 7 R21's Dialysis Communications Record dated 2/29/16, included direction from the dialysis unit to facility staff to: "Please help pt [patient] control fluid intake in between tx's d/t [due to] high fluid gains and unable to get fluid off. Pt refused extra tx's to help /c [with] additional fluid removal." When interviewed on 3/24/16, at 12:55 p.m. RN-B stated that R21 was on 1500 cc per day fluid restriction and that the nurse after each shift is responsible for documented the total fluids R21 consumed on the shift. RN-B observed the cup of water in R21's room and stated she wasn't sure where it came from and shouldn't have water at her bedside. RN-B further stated there was not any guidance on what dietary and nursing are to provide for fluids on each shift. When interviewed on 3/24/16, at 1:07 p.m. R21 stated she received the cup from dialysis and knows she is on fluid restrictions, but does not know what the restrictions are exactly and has been told she drinks too much fluids. R21 further stated she does not obtain drinks on her own and the facility manages her fluid intake. Staff ask her what she wants to drink and then they bring it to her. She does tell night staff fill her ice water for her and receives all the water, juice, coffee, ice cream and whatever she wants at activities. When interviewed on 3/24/16, at 1:20 p.m. RN-D stated R21 was on a 1500 cc fluid restriction and has been educated on how much fluids she is supposed to have. Nursing is supposed to document the intake from meals, med passes and any other fluid consumed for each shift but isn't sure if the documentation reflects all the fluids she drinks or eats for each shift.	F 309		

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F 309	Continued From page 8 When interviewed on 3/24/16, at 2:20 p.m. the director of nursing (DON) stated a visual cue of a water glass with a line drawn through posted outside the residents room lets staff know to talk to the nurse regarding fluid consumption. The DON stated that nurses are to calculate how much R21 drinks on their shift and that the next shift needs to determine how much more fluid she can have on their shift. The DON stated that the facility is watching her fluid intake and that she expects staff to give R21 what she wants to drink but provide education and reminders regarding her fluid restrictions. Review of the progress notes from November 2015 to March 2016, identified R21 had several occasions when she consumed over 1500 cc of fluid. R21's quarterly nutrition assessment dated 2/10/16, indicated R21 had a 1500 cc fluid restriction and consumes greater than 5 cups of fluids per day (a cup is approximately 190 cc). The assessment identified fluid gains were above the recommended range and drinks 360 cc per meal. The assessment further indicated R21 was non-compliant with fluid restrictions and recommended no changes as R21 had been provided diet education with little success. No referrals were indicated. When interviewed via telephone on 3/24/16, at 2:50 p.m. the facility registered dietician (RD) stated that R21 was 100 percent non- compliant with her fluid restrictions and has been battling fluid gains all year. The RD could not be specific on how R21 was non- compliant but did state that she drinks too many fluids at meals and eats ice	F 309		

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F 309	Continued From page 9	F 309		

cream. The RD further stated that a fluid schedule should be available to staff with specifics on what R21 should receive from nursing and dietary each shift and that the dietary card should be specific regarding how much fluids should be served with each meal. The RD stated that R21 should not have fluids at bedside and this was difficult to track everything that R21 consumed because of her activity attendance.

When interviewed on 3/24/16, at 3:06 p.m. the culinary services director (CSD) stated that there is nothing specific documented for fluid restriction breakdown between nursing and dietary. The CSD stated that on the dietary card it should state the amount of fluids to be provided at each meal for R21. After visualizing the dietary card the CSD verified that the dietary card only listed a 1500 cc a day fluid restriction.

When interviewed via telephone on 3/24/16, at 12:29 p.m. the dialysis registered nurse (RN)-A stated that R21 typically comes in high on fluid gains averages and averages 4 to 4 1/2 kilograms (kg) of fluid are removed on dialysis day. RN-A stated that R21's fluid restrictions need to be closely monitored and her restriction could not possibly be adhered to as she could not remember the last time R21 was at her dry weight. RN-A stated that dialysis has been in contact with the facility and has been told R21 had been following her fluid restrictions, however if R21 was following her restrictions she would not need as much fluid removed.

Although R21 was on a 1500 fluid restriction because of renal failure, the facility was not consistently providing and monitoring all of R21's fluid consumption which has caused fluid gains

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F 309	Continued From page 10 making it difficult to have this fluid removed during her dialysis treatments. The undated facility policy Fluid Restrictions indicated "Nursing staff and dietary services will provide for restrictions of fluids upon order of physician." The policy further identified " Licensed staff along with dietary staff will determine amount of fluids that can be consumed at each meal and each shift. In addition, "dietary will note fluid restrictions on diet tray card system and nursing staff will provide additional fluid up to limit for each shift. Large quantities of fluids should not be left at the bedside."	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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 comprehensively assess and develop interventions to promote continence for 1 of 2 residents (R19) reviewed for urinary incontinence. Findings include:	F 315	The toileting needs of R19 have been assessed, resident specific interventions have been developed and implemented. All residents have the potential for same deficient practice. Facility will review/assess all incontinent residents to ensure appropriate Care Plan approaches	4/17/16

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F 315	Continued From page 11 R19's quarterly Minimum Data Set (MDS) dated 12/24/15, identified R19 had severe cognitive impairment, required extensive assistance with toileting, and was frequently incontinent of urine but had never been trialed on a toileting program since admitted to the facility. The 9/28/15 quarterly MDS also identified, she was frequently incontinent of urine, with no trialed toileting program, and the 7/15/15 admission MDS assessment identified R19 had a urinary catheter. During observation on 3/22/16, at 11:55 a.m. R19 was seated in her wheelchair in the dining room eating lunch, and had a strong odor of urine present about her. R19 did not have any visible catheter drainage collection device present. During observation of care on 3/23/15, at 5:56 p.m. R19 was assisted into a community bathroom by nursing assistant (NA)-A. At 6:00 p.m. the bathroom door was opened, and R19 wheeled herself out of the bathroom. NA-A followed R19 out of the bathroom carrying a clear plastic bag with a soiled incontinence product inside. When interviewed on 3/23/16, at 6:02 p.m. NA-A stated R19 had been incontinent of, "A little" urine when assisted to the bathroom. At times, R19 was able to tell staff when she needed to use the bathroom but staff, "Have to ask her a lot." NA-A stated R19 will still void after being assisted to the toilet, even after being incontinent, but was unaware if a formal toileting plan for R19 was in place, "We just take her every 2 hours." R19's Clinical Documentation assessment dated 7/22/15, identified R19 used an indwelling	F 315	are in place and make needed adjustments as indicated by assessments. Bowel and bladder assessments will be completed for new admissions, upon annual review and with significant changes to assess the toileting needs of all residents. Interventions put into place based on assessment findings. Audits of 3 random residents will be completed weekly for one month and then monthly x 3 months and will included monitoring that bowel and bladder assessment was completed, toileting plan is in care plan and being implemented. Audits will be completed by clinical managers or designees. Analysis of the observations/audits and facilities compliance will be presented to our Quality Council and approved by the Administrator. The Quality Council will implement needed changes and determine the need to on-going monitoring/auditing after analysis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

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F 315	Continued From page 12	F 315		

catheter, and was frequently incontinent of bowel. The assessment contained no further information on R19's urinary elimination.

R19's most recent Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 7/4/15, identified R19 had an indwelling catheter, and had no urinary incontinence.

R19's care plan dated 1/29/16, identified R19 had, "Impaired elimination d/t [due to] requiring assistance with toileting." R19 required a Foley catheter for elimination, however, "[Had] now been removed and voiding without concerns." R19 was identified as incontinent of bladder, and the care plan directed staff to, "Check and change incontinence products q [every] 2 hrs [two hours] and prn [as needed]."

R19's medical record was reviewed, and no further comprehensive assessments of R19's urinary elimination were identified since 7/22/15, when R19 had been identified to have a catheter in place to manage her urinary elimination. There was no indication a comprehensive assessment had been completed to determine type of incontinence, history of urinary incontinence, bladder infections, hydration, medications, behaviors, environmental factors, and was a voiding pattern identified for R19.

During interview on 3/24/16, at 12:02 p.m. registered nurse (RN)-E reviewed R19's medical record and stated R19 had not been comprehensively assessed for urinary elimination, "Since last June" when she had a catheter in place, but R19's catheter had been discontinued shortly after admission nearly one

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F 315	Continued From page 13 year prior, "[We] got rid of that in pretty short order." RN-E stated a comprehensive bladder assessment would include review of residents' risks for incontinence, intake patterns, medical conditions and medications which may impair their elimination, and R19 had never been assessed for these things since having her catheter removed, "[I'm] not sure why she's fallen through the cracks." RN-E stated most of R19's incontinence happened during the night hours, but if she had been comprehensively assessed for her urinary elimination, a plan could have been developed to potentially reduce her incontinence. An undated facility Bowel and Bladder Assessment policy identified a purpose, "To assess the toileting needs of all residents and determine appropriateness of retraining and / or individualized toileting schedules." The policy directed staff to assess a resident upon admission, annual reviews or with significant changes using the facility assessment tool, and develop "An individualized care plan" with the collected data.	F 315		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adaptive equipment was provided for 1 of 1 residents (R13) who required adaptive equipment to	F 369	R13 has been given a plate guard and non skid place mat for all three meals as per care plan. All residents have the potential to be	4/17/16

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F 369	Continued From page 14 promote independence with eating. Findings include: R13's annual Minimum Data Set (MDS) dated 1/9/16, indicated R13 had severe cognitive impairment and required supervision for eating. R13's Nutritional Care Area Assessment (CAA) dated 1/14/16, identified R13 was independent at meals after tray set up and adaptive equipment was provided. R13's Physician Order Report dated 2/4/16, identified R13 had dementia, paraplegia (paralysis of the lower half of the body), dysphagia (difficulty swallowing), and nutritional deficiency. Further, R13 had a current physician order for, "Plate guard with non-skid mat, Normal utensils, place plate at edge of table, and glasses directly above plate." R13's care plan dated 1/27/16, identified R13 had, "Nutrition concerns ... Dementia and difficulty feeding self m/b [manifested by] need for adaptive equipment and a therapeutic diet..." The care plan directed staff to, "Provide plate guard with non-skid mat with plate guard arch facing her. Tray set up at all meals." During observation on 3/23/16, at 5:24 p.m. R13 was provided supper which consisted of a salami sandwich, baked beans, and cut up watermelon. R13's meal was served on a regular plate and placed on a green paper placemat in front of her. There was no plate guard or non-skid mat provided to R13 as directed by her physician orders and care plan. R13 held the fork in her left hand and attempted to eat the baked beans	F 369	affected by same deficient practice. All residents with adaptive equipment have been reviewed to ensure that they are receiving the equipment. Weekly audits will be conducted for one month and then monthly x 3 until compliance is fully achieved. Results of audits will be reviewed at Quality Council for further recommendations and/or follow up. Culinary Director, DON, and/or designees to monitor.	

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F 369	Continued From page 15	F 369		

and cut up watermelon, however; R13 spilled food off the edge of the plate as she attempted to eat. When R13 finished her meal, she had several pieces of cut up watermelon and several baked beans on the table.

During interview on 3/24/16, at 12:19 p.m. culinary service director (CSD) stated R13's plate guard should be at the bottom of her plate, and a non-skid mat under R13's plate. This was an error, and the care plan was not followed. When interviewed on 3/24/16, at 2:41 p.m. licensed practical nurse (LPN)-A stated R13 received orders from occupational therapy (OT) for a plate guard and non-skid mat. LPN-A stated dietary staff should be following any orders for adaptive equipment for R13, and all staff are educated on adaptive equipment for each resident during daily report.

During interview on 3/24/16, at 3:09 p.m. occupational therapist (OT)-A stated OT recommended R13 to use a plate guard and a non-skid mat under her plate because R13 needed assistance with her meals mostly due to her, "Cognition and vision problems." OT-A stated she expected OT recommendations to be followed, and R13 should have been provided a plate guard and non-skid mat as directed.

A facility Adaptive Feeding Equipment policy dated 11/2007, indicated, "Residents will be provided with adaptive feeding equipment upon assessment by the licensed nursing and therapies staff." Further, the policy directed, "Nursing staff, together with Dietary, will see that the devices are available during mealtimes."

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	245459	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/23/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on March 23, 2016. At the time of this survey, Building 01 of Benedictine Living Community Winsted was found not 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 Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

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

Electronically Signed — 04/13/2016

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
	245459	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/23/2016**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Building 01 of Benedictine Living Community Winsted consists of the original 1960 building. It is two-stories in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type I(332) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a licensed capacity of 65 beds and had a census of 55 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a	K 027		4/17/16

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K 027	Continued From page 2 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Findings include: During the facility tour on 03/23/2016 between 8:45am and 11:30am, revealed that: 1) Smoke barrier doors by room 108 would not close when tested. This deficiency was verified by Environmental Services Director.	K 027	All smoke barrier doors will be checked on a monthly basis for proper closure and functioning. This will be completed when Fire Drills are conducted. Documentation will be included on the Fire Drill Report and results of monthly checks will be reviewed at monthly Quality council meetings. Environmental Director or Plant Operations Manager will conduct monthly checks.	
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		4/17/16

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	245459	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/23/2016**

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K 062	Continued From page 3 This STANDARD is not met as evidenced by: Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Findings include: During documentation review on 03/23/2016 between 8:45am and 11:30am, revealed that: 1) Fire Sprinkler System was not tested within 365 days. Current annual test was on 06/24/2015 previous inspection was 06/12/2014 This deficiency was verified by Environmental Services Director.	K 062	Plant Operations Manager will contact contracted company (Gilbert Mechanical) one month prior to inspection due date and set up an inspection date. This check will be included on the TELS Preventative Maintenance program. Inspection results will be reviewed annually at the Quality council meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING **02 - NEW MAIN ENTRANCE** B. WING _____	**03/23/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on March 23, 2016. At the time of this survey, Building 02 of Benedictine Living Community Winsted was found not 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 Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/13/2016

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Building 02 of Benedictine Living Community Winsted was constructed in 2011, is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a licensed capacity of 65 beds and had a census of 55 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are	K 062		4/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING **02 - NEW MAIN ENTRANCE** B. WING _____	**03/23/2016**

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K 062	Continued From page 2 inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 During documentation review on 03/23/2016 between 8:45am and 11:30am, revealed that: 1) Fire Sprinkler System was not tested within 365 days. Current annual test was on 06/24/2015 previous inspection was 06/12/2014 This deficiency was verified by Environmental Services Director.	K 062	Plant Operations Manager will contact sprinkler vendor one month prior to inspection due date and set up appointment for annual, timely inspections. The annual check will also be included on the TEL's maintenance program and results of annual checks will be reviewed by Quality Council for further action or recommendations.	

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
April 7, 2016

Ms. Terry Rieck, Administrator
Benedictine Living Community, Winsted
551 Fourth Street North
Winsted, Minnesota 55395-0750

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5459026

Dear Ms. Rieck:

The above facility was surveyed on March 22, 2016 through March 24, 2016 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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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 Brenda Fischer, Unit Supervisor (320)223-7338.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00352	A. BUILDING: _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 3/22/2016 through 3/24/2016 surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills.	2 302		3/25/16

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2 302	Continued From page 2 (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents and interested family were provided information regarding the frequency staff received Alzheimer's dementia training. This had the potential to affect all current and future residents of the facility and other interested persons. Findings include: A review of staff training records on 3/23/2016 at 3:50 p.m. indicated the facility utilized a series of computer-based courses to educate staff on providing care to residents with dementia. The course descriptions identified training objectives to include: an introduction to Alzheimer's disease and dementia; communication; activities of daily living; and behaviors versus symptoms. The facility provided documented evidence that all staff received dementia training: A multi-series training was required upon hire, and annually thereafter, with a "Dementia Refresher Course." A review of the facility's resident admission packet, given to residents and families, did not include information as to the frequency the staff dementia training. In an interview on 3/24/2016 at 1:39 p.m. the	2 302	Corrected	

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2 302	Continued From page 3 social services designee (SS) stated the admission packet provided to consumers "does not provide" information regarding the frequency of dementia training provided to the staff. The SS stated sheet "definitely can be tweaked" and adjusted to meet the requirements. In an interview on 3/24/2016 at 3:55 p.m., the facility administrator stated she thought the admission package information "was adequate," but acknowledged the frequency of the staff training was not disclosed. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review its process to ensure: Alzheimer's training is timely completed by both facility and contracted nursing staff; and residents and interested others are made aware that dementia training is provided to staff, who received training, the frequency of training, and a description of the training topics. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 565	Corrected	4/17/16

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2 565	Continued From page 4 review, the facility failed to ensure nutritional care plan interventions were followed for 1 of 1 residents (R13) reviewed for nutrition. Findings include: R13's annual Minimum Data Set (MDS) dated 1/9/16, indicated R13 had severe cognitive impairment and required supervision for eating. R13's care plan dated 1/27/16, identified R13 had, "Nutrition concerns ... Dementia and difficulty feeding self m/b [manifested by] need for adaptive equipment and a therapeutic diet..." The care plan directed staff to, "Provide plate guard with non-skid mat, with plate- guard arch facing her. Tray set up at all meals." On 3/23/16, at 5:24 p.m. R13 was provided supper which consisted of a salami sandwich, baked beans, and cut up watermelon. R13's meal was served on a regular plate and placed on a green paper placemat in front of her. There was no plate guard or non-skid mat provided to R13 as directed by the care plan. R13 held the fork in her left hand and attempted to eat the baked beans and cut up watermelon; however, R13 spilled food off the edge of the plate as she attempted to eat. When R13 finished her meal, she had several pieces of cut up watermelon and several baked beans on the table. During interview on 3/24/16, at 12:19 p.m. culinary service director (CSD) stated R13's plate guard should be at the bottom of her plate, and a non-skid mat under R13's plate. This was an error, and the care plan was not followed. When interviewed on 3/24/16, at 3:09 p.m. occupational therapist (OT)-A stated R13 should	2 565		

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2 565	Continued From page 5 have been provided a plate guard and a non-skid mat under her plate because R13 needed assistance with her meals mostly due to her, "Cognition and vision problems." A policy regarding resident care plans was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		4/17/16

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2 830	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide specific guidelines for staff to effectively provide fluid restrictions for 1 of 1 residents (R21) reviewed for dialysis. Findings include: R21's annual Minimum Data Set (MDS) dated 11/9/15, indicated R21 was cognitively intact, did not not reject any care and needed supervision while eating. The MDS identified a diagnosis of renal failure and was receiving dialysis treatments. R21's nutritional Care Area Assessment (CAA) dated 11/9/15, identified R21 was at nutritional risk due to an order for 1500 cubic centimeters (cc) of fluid per day and R21 was observed to have dry lips and mouth, related to fluid restrictions and being a hemodialysis patient. The CAA further identified that the resident may experience thirst and may be at risk for going over fluid requirements. However, the CAA did not address a plan for R21's fluid restrictions. R21's Physician Order Report signed 12/8/15, ordered 1500 cc of fluid per day with a start date of 11/17/14. R21's nutrition care plan dated 12/12/14, identified dietary was to provide R21 with a 1500 cc fluid restriction at meals and to record fluid intakes daily to assure appropriate amounts of fluid. The care plan did not identify how much fluid to provide at each meal for R21.	2 830	Corrected	

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2 830	Continued From page 7 R21's hemodialysis care plan dated 11/30/15, identified R21 went to the dialysis clinic Monday, Wednesday and Fridays. The care plan included a fluid restriction of 1500 cc/24 hours and directed the staff to remind and encourage R21 to follow restrictions as R21 is often non- compliant. In addition the care plan further directed staff to monitor and record fluid intake every shift and for the night shift to record fluid intake in the electronic medical record. The care plan did not identify how much fluid nursing should provide for each shift. During observation on 3/23/16, at 5:11 p.m. R21 was served 240 cc's of ice water, 240 cc's of juice and 240 cc's of coffee at her table setting for at total of 720 cc served to her by the dietary staff for the dinner meal. The dietary tray card on the table identified a 1500 cc fluid restriction but did not provide instruction for how much fluid should be served with each meal. On 3/24/16, at 7:03 a.m. a clear water glass with a lid and straw with approximately 360 cc's of water in it was on R21's bedside table. The cup could hold 480 cc's. Written on the lid of the glass was "max 6 cups per day." This was in addition to the 1500 cc dietary was providing for R21. On 3/24/16, at 7:58 a.m. R21 was served by dietary staff 240 cc of ice water, 240 cc of juice and 240 cc of coffee at her table setting for at total of 720 cc served to her by the dietary staff for the breakfast meal. When interviewed on 3/24/16, at 8:41 a.m. dietary aid (DA)-A stated she wasn't sure what R21's fluid restrictions were but thought they were 1200 cc a day. DA-A wasn't sure on how much fluids she was to have at each meal, but thinks it is 420	2 830		

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2 830	Continued From page 8 cc at each meal. She stated that R21 requests ice water for chewing,and if she requests more fluid that is provided during the meal we remind her of her fluid restrictions and then give her what she requested. When interviewed on 3/24/16, at 12:53 p.m. nursing assistant (NA)-B reported that R21 was kind of restricted with water in her room, but does not know what her restrictions were. NA-B further stated that the aids used to track fluid intake in her room, but no longer are. The nursing assistant care sheet identified R21 was on fluid restrictions, but did not identify the the fluid restriction amount or how to track fluid intake. Review of R21's Dialysis Communications Record dated 12/21/15, included direction from the dialysis unit to facility staff : " Fluid restriction 1500 cc/ daily. Please assist [R21] /c [with] fluid management. She gained 12.5 lbs. [pounds] since Friday." R21's Dialysis Communications Record dated 12/26/15, included direction from the dialysis unit to facility staff to: " ...during tx's, large amt [amount] of fluid gain over 14 lbs over holiday break (2 days)." R21's Dialysis Communications Record dated 2/29/16, included direction from the dialysis unit to facility staff to: "Please help pt [patient] control fluid intake in between tx's d/t [due to] high fluid gains and unable to get fluid off. Pt refused extra tx's to help /c [with] additional fluid removal." When interviewed on 3/24/16, at 12:55 p.m. RN-B stated that R21 was on 1500 cc per day	2 830		

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2 830	Continued From page 9 fluid restriction and that the nurse after each shift is responsible for documented the total fluids R21 consumed on the shift. RN-B observed the cup of water in R21's room and stated she wasn't sure where it came from and shouldn't have water at her bedside. RN-B further stated there was not any guidance on what dietary and nursing are to provide for fluids on each shift. When interviewed on 3/24/16, at 1:07 p.m. R21 stated she received the cup from dialysis and knows she is on fluid restrictions, but does not know what the restrictions are exactly and has been told she drinks too much fluids. R21 further stated she does not obtain drinks on her own and the facility manages her fluid intake. Staff ask her what she wants to drink and then they bring it to her. She does tell night staff fill her ice water for her and receives all the water, juice, coffee, ice cream and whatever she wants at activities. When interviewed on 3/24/16, at 1:20 p.m. RN-D stated R21 was on a 1500 cc fluid restriction and has been educated on how much fluids she is supposed to have. Nursing is supposed to document the intake from meals, med passes and any other fluid consumed for each shift but isn't sure if the documentation reflects all the fluids she drinks or eats for each shift. When interviewed on 3/24/16, at 2:20 p.m. the director of nursing (DON) stated a visual cue of a water glass with a line drawn through posted outside the residents room lets staff know to talk to the nurse regarding fluid consumption. The DON stated that nurses are to calculate how much R21 drinks on their shift and that the next shift needs to determine how much more fluid she can have on their shift. The DON stated that the facility is watching her fluid intake and that	2 830		

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2 830	Continued From page 10 she expects staff to give R21 what she wants to drink but provide education and reminders regarding her fluid restrictions. Review of the progress notes from November 2015 to March 2016, identified R21 had several occasions when she consumed over 1500 cc of fluid. R21's quarterly nutrition assessment dated 2/10/16, indicated R21 had a 1500 cc fluid restriction and consumes greater than 5 cups of fluids per day (a cup is approximately 190 cc). The assessment identified fluid gains were above the recommended range and drinks 360 cc per meal. The assessment further indicated R21 was non-compliant with fluid restrictions and recommended no changes as R21 had been provided diet education with little success. No referrals were indicated. When interviewed via telephone on 3/24/16, at 2:50 p.m. the facility registered dietician (RD) stated that R21 was 100 percent non- compliant with her fluid restrictions and has been battling fluid gains all year. The RD could not be specific on how R21 was non- compliant but did state that she drinks too many fluids at meals and eats ice cream. The RD further stated that a fluid schedule should be available to staff with specifics on what R21 should receive from nursing and dietary each shift and that the dietary card should be specific regarding how much fluids should be served with each meal. The RD stated that R21 should not have fluids at bedside and this was difficult to track everything that R21 consumed because of her activity attendance. When interviewed on 3/24/16, at 3:06 p.m. the culinary services director (CSD) stated that there	2 830		

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2 830	Continued From page 11	2 830		

is nothing specific documented for fluid restriction breakdown between nursing and dietary. The CSD stated that on the dietary card it should state the amount of fluids to be provided at each meal for R21. After visualizing the dietary card the CSD verified that the dietary card only listed a 1500 cc a day fluid restriction.

When interviewed via telephone on 3/24/16, at 12:29 p.m. the dialysis registered nurse (RN)-A stated that R21 typically comes in high on fluid gains averages and averages 4 to 4 1/2 kilograms (kg) of fluid are removed on dialysis day. RN-A stated that R21's fluid restrictions need to be closely monitored and her restriction could not possibly be adhered to as she could not remember the last time R21 was at her dry weight. RN-A stated that dialysis has been in contact with the facility and has been told R21 had been following her fluid restrictions, however if R21 was following her restrictions she would not need as much fluid removed.

Although R21 was on a 1500 fluid restriction because of renal failure, the facility was not consistently providing and monitoring all of R21's fluid consumption which has caused fluid gains making it difficult to have this fluid removed during her dialysis treatments.

The undated facility policy Fluid Restrictions indicated "Nursing staff and dietary services will provide for restrictions of fluids upon order of physician." The policy further identified " Licensed staff along with dietary staff will determine amount of fluids that can be consumed at each meal and each shift. In addition, "dietary will note fluid restrictions on diet tray card system and nursing staff will provide additional fluid up to limit for each shift. Large quantities of fluids should not

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2 830	Continued From page 12 be left at the bedside." SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review and revise policies and procedures related to fluid and intake monitoring, and provide staff education related to the care of residents who receive dialysis treatment. The director of nursing or designee could develop an audit tool to ensure appropriate, timely and comprehensive fluid monitoring is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. 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 MN Requirement is not met as evidenced by: Based on observation, interview and document	2 910	Corrected	4/17/16

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2 910	Continued From page 13 review, the facility failed to comprehensively assess and develop interventions to promote continence for 1 of 2 residents (R19) reviewed for urinary incontinence. Findings include: R19's quarterly Minimum Data Set (MDS) dated 12/24/15, identified R19 had severe cognitive impairment, required extensive assistance with toileting, and was frequently incontinent of urine but had never been trialed on a toileting program since admitted to the facility. The 9/28/15 quarterly MDS also identified, she was frequently incontinent of urine, with no trialed toileting program, and the 7/15/15 admission MDS assessment identified R19 had a urinary catheter. During observation on 3/22/16, at 11:55 a.m. R19 was seated in her wheelchair in the dining room eating lunch, and had a strong odor of urine present about her. R19 did not have any visible catheter drainage collection device present. During observation of care on 3/23/15, at 5:56 p.m. R19 was assisted into a community bathroom by nursing assistant (NA)-A. At 6:00 p.m. the bathroom door was opened, and R19 wheeled herself out of the bathroom. NA-A followed R19 out of the bathroom carrying a clear plastic bag with a soiled incontinence product inside. When interviewed on 3/23/16, at 6:02 p.m. NA-A stated R19 had been incontinent of, "A little" urine when assisted to the bathroom. At times, R19 was able to tell staff when she needed to use the bathroom but staff, "Have to ask her a lot." NA-A stated R19 will still void after being assisted to the toilet, even after being incontinent, but was	2 910		

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2 910	Continued From page 14 unaware if a formal toileting plan for R19 was in place, "We just take her every 2 hours." R19's Clinical Documentation assessment dated 7/22/15, identified R19 used an indwelling catheter, and was frequently incontinent of bowel. The assessment contained no further information on R19's urinary elimination. R19's most recent Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 7/4/15, identified R19 had an indwelling catheter, and had no urinary incontinence. R19's care plan dated 1/29/16, identified R19 had, "Impaired elimination d/t [due to] requiring assistance with toileting." R19 required a Foley catheter for elimination, however, "[Had] now been removed and voiding without concerns." R19 was identified as incontinent of bladder, and the care plan directed staff to, "Check and change incontinence products q [every] 2 hrs [two hours] and prn [as needed]." R19's medical record was reviewed, and no further comprehensive assessments of R19's urinary elimination were identified since 7/22/15, when R19 had been identified to have a catheter in place to manage her urinary elimination. There was no indication a comprehensive assessment had been completed to determine type of incontinence, history of urinary incontinence, bladder infections, hydration, medications, behaviors, environmental factors, and was a voiding pattern identified for R19. During interview on 3/24/16, at 12:02 p.m. registered nurse (RN)-E reviewed R19's medical record and stated R19 had not been	2 910		

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2 910	Continued From page 15 comprehensively assessed for urinary elimination, "Since last June" when she had a catheter in place, but R19's catheter had been discontinued shortly after admission nearly one year prior, "[We] got rid of that in pretty short order." RN-E stated a comprehensive bladder assessment would include review of residents' risks for incontinence, intake patterns, medical conditions and medications which may impair their elimination, and R19 had never been assessed for these things since having her catheter removed, "[I'm] not sure why she's fallen through the cracks." RN-E stated most of R19's incontinence happened during the night hours, but if she had been comprehensively assessed for her urinary elimination, a plan could have been developed to potentially reduce her incontinence. An undated facility Bowel and Bladder Assessment policy identified a purpose, "To assess the toileting needs of all residents and determine appropriateness of retraining and / or individualized toileting schedules." The policy directed staff to assess a resident upon admission, annual reviews or with significant changes using the facility assessment tool, and develop "An individualized care plan" with the collected data. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review and revise policies and procedures related to monitoring and provision of incontinence care, and provide staff education related to the care of residents with urinary incontinence. The director of nursing or designee could develop an audit tool to ensure appropriate and timely assessment and incontinence care are provided.	2 910		

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2 910	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 945	MN Rule 4658.0530 Subp. 1 Assistance with Eating - Nursing Personnel Subpart 1. Nursing personnel. Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adaptive equipment was provided for 1 of 1 residents (R13) who required adaptive equipment to promote independence with eating. Findings include: R13's annual Minimum Data Set (MDS) dated	2 945	Corrected	4/17/16

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2 945	Continued From page 17 1/9/16, indicated R13 had severe cognitive impairment and required supervision for eating. R13's Nutritional Care Area Assessment (CAA) dated 1/14/16, identified R13 was independent at meals after tray set up and adaptive equipment was provided. R13's Physician Order Report dated 2/4/16, identified R13 had dementia, paraplegia (paralysis of the lower half of the body), dysphagia (difficulty swallowing), and nutritional deficiency. Further, R13 had a current physician order for, "Plate guard with non-skid mat, Normal utensils, place plate at edge of table, and glasses directly above plate." R13's care plan dated 1/27/16, identified R13 had, "Nutrition concerns ... Dementia and difficulty feeding self m/b [manifested by] need for adaptive equipment and a therapeutic diet..." The care plan directed staff to, "Provide plate guard with non-skid mat with plate guard arch facing her. Tray set up at all meals." During observation on 3/23/16, at 5:24 p.m. R13 was provided supper which consisted of a salami sandwich, baked beans, and cut up watermelon. R13's meal was served on a regular plate and placed on a green paper placemat in front of her. There was no plate guard or non-skid mat provided to R13 as directed by her physician orders and care plan. R13 held the fork in her left hand and attempted to eat the baked beans and cut up watermelon, however; R13 spilled food off the edge of the plate as she attempted to eat. When R13 finished her meal, she had several pieces of cut up watermelon and several baked beans on the table.	2 945		

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2 945	Continued From page 18 During interview on 3/24/16, at 12:19 p.m. culinary service director (CSD) stated R13's plate guard should be at the bottom of her plate, and a non-skid mat under R13's plate. This was an error, and the care plan was not followed. When interviewed on 3/24/16, at 2:41 p.m. licensed practical nurse (LPN)-A stated R13 received orders from occupational therapy (OT) for a plate guard and non-skid mat. LPN-A stated dietary staff should be following any orders for adaptive equipment for R13, and all staff are educated on adaptive equipment for each resident during daily report. During interview on 3/24/16, at 3:09 p.m. occupational therapist (OT)-A stated OT recommended R13 to use a plate guard and a non-skid mat under her plate because R13 needed assistance with her meals mostly due to her, "Cognition and vision problems." OT-A stated she expected OT recommendations to be followed, and R13 should have been provided a plate guard and non-skid mat as directed. A facility Adaptive Feeding Equipment policy dated 11/2007, indicated, "Residents will be provided with adaptive feeding equipment upon assessment by the licensed nursing and therapies staff." Further, the policy directed, "Nursing staff, together with Dietary, will see that the devices are available during mealtimes." SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review and revise policies and procedures related to assistance with eating and provide staff education related to the care of residents who use assistive devices to promote independence. The director of nursing or designee could develop an audit tool to ensure appropriate appropriate assistance and	2 945		

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2 945	Continued From page 19 equipment are provided to promote resident independence. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 945		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a required two step tuberculin skin test (TST) was completed for 3 of 5 employees (RN-F, NA-E, and NA-F), and a symptom screening was completed for 1 of 5	21426	Corrected	4/17/16

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21426	Continued From page 20 employees (NA-F). Further, the facility failed to have a completed Facility Tuberculosis (TB) Risk Assessment Worksheet for Health Care Settings Licensed by the Minnesota Department of Health. Findings include: Registered nurse (RN)-F's Mantoux (Tuberculosis) Test Form dated 11/2/15, and 11/11/14/15, identified both TST tests to be negative. However, the documentation did not identify millimeters (mm) of induration. Nursing assistant (NA)-E's Mantoux (Tuberculosis) Test Form dated 1/27/16, and 2/16/16, identified zero mm induration. However, the documentation did not identify if the test was negative or positive. NA-F's Mantoux (Tuberculosis) Test Form, undated, identified no first or second TST were completed, and no symptom screening was completed. When interviewed on 3/24/16, at 4:45 p.m. director of nursing (DON) stated a new risk assessment was just completed on 3/24/16, for the facility, as she was unable to locate a current assessment. Facility policy titled "2 step Mantoux Procedure" dated 12/9/11, identified the nurse will measure the induration and record onto the screening tool for health care workers in millimeters. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review the facility's process to ensure TB testing for newly admitted residents is documented as	21426		

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21426	Continued From page 21 required by state rule. They could also revise their policy to ensure millimeters of induration and the interpretations of the results are documented as per the recommendations of the Centers for Disease Control (CDC). Nursing staff could be re-educated on new processes and policy revisions. An auditing system could be developed and reviewed by the facility's quality assessment and assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21426		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a dignified rising and morning routine for 1 of 4 residents (R28) observed for activities of daily living. Findings include: R28's quarterly Minimum Data Set (MDS) dated 1/7/16, identified R28 had severe cognitive impairment, and required total dependence on staff for bed mobility, transferring, dressing, and personal hygiene. R28's plan of care dated 1/11/16, identified staff	21805	Corrected	4/17/16

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21805	Continued From page 22 are to provide total assist with dressing and grooming. During observation on 3/24/16 at 6:59 a.m., nursing assistant (NA)-C and NA-D entered R28's room to provide personal cares. After completing personal cares, they placed an incontinent brief on R28, and put her pants on while in bed. They pulled her pants up so they were just above her the knees, but below the incontinent brief. They placed the bedding covers over R28, and left the room. When interviewed on 3/24/16, at 7:08 a.m. upon exiting R28's room, NA-C stated R28 will remain in bed at this time, and staff will assist in getting her into her wheelchair around 8:00 a.m. for breakfast. Registered nurse (RN)-E and surveyor observed R28 in bed on 3/24/16, at 8:32 a.m., covered with sheets and bed spread. RN-E removed R28's bedding, and saw R28's with her pants on, pulled up between her knees and incontinent pad, making it difficult for R28 to move in bed. RN-E stated, this should not happen, because this would be "undignified" for the resident. When interviewed on 3/24/16, at 12:33 p.m. NA-C stated staff typically leave R28's pants down below her incontinent pad, because they will check if R28 has been incontinent prior to getting her up in the chair for breakfast. When interviewed on 3/24/16, at 2:54 p.m. director of nursing (DON) stated she would expect that resident either have their pants pulled all the way up around the waist or removed completely when in bed. It was not acceptable for residents to have their pants down below the incontinent pad and above the knees when in	21805		

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21805	Continued From page 23 bed. A facility policy regarding resident dignity was requested, but none provided. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review and revise policies and procedures related to dignity and provision of care, and provide staff education to reinforce the provision of dignified care. The director of nursing or designee could develop an audit tool to ensure appropriate, timely and dignified resident care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		