CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: TN48

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	HE STATI	E SURVEY AG	ENCY	F	acility ID: 00352
MEDICARE/MEDICAID PROVIDER N (L1) 245459 2 STATE VENIDOR OR MEDICAID NO.	(L1) 245459 (L3) BENEDICTINE LIVING COMM ITATE VENDOR OR MEDICAID NO. (L4) 551 FOURTH STREET NORTH						4. TYPE OF ACTION: 1. Initial	7 (L8) 2. Recertification
(L2) 787477100		(L5) WINSTED, N			(L6)	55395	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9) 02/01/2011	NERSHIP	7. PROVIDER/SUB		Y 09 ESRD	02 (L7)) 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other mplaint
6. DATE OF SURVEY 05/10 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) — (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	65 (L18) 65 (L17)	X A. In Complian Program Re Compliance1. A B. Not in Com	quirements		2. Tech 3. 24 F 4. 7-Da	nnical Personnel Hour RN ay RN (Rural SNF) Safety Code A*	Following Requirements: 6. Scope of Servi 7. Medical Direc 8. Patient Room S 9. Beds/Room (L12)	tor
18 SNF 18/19 SNF 65	19 SNF	ICF	IID		1861 (e) (1) or		(L15)	
(L37) (L38) 16. STATE SURVEY AGENCY REMARI	(L39) KS (IF APPLICABLE S	(L42) HOW LTC CANCELL	(L43) LATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	VEY AGENCY APP	PROVAL	Date:
Brenda Fischer, Ur	nit Supervisor	<u>r</u>	05/10/2016	(L19)	Kate John	nsTon, Pro	gram Specialist	05/20/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE OR S	SINGLE STAT	E AGENCY	
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Par 2. Facility is not Eligible			IPLIANCE WITH C	IVIL	2. (al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	L-1513)
22. ORIGINAL DATE OF PARTICIPATION 04/01/1987 (L24)	23. LTC AGREEMI BEGINNING I		24. LTC AGREEME ENDING DATI (L25)		26. TERMINAT VOLUNTARY 01-Merger, Closu 02-Dissatisfaction	_00		L30) CARY eet Health/Safety eet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension of B. Rescind Susp	of Admissions:	(L44) (L45)		03-Risk of Involu 04-Other Reason		OTHER 07-Provider 00-Active	Status Change
28. TERMINATION DATE:	(L28)	. INTERMEDIARY/C	ARRIER NO.	(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539	32 (L32)	DETERMINATION (04/26/2016	OF APPROVAL DAT	(L33)	DETERMINA	ATION APPROV	VAL	



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.

Benedictine Living Community Winsted May 20, 2016 Page 2

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



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.

Benedictine Living Community Winsted May 20, 2016 Page 2

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
245459 _{Y1}	B. Wing	Y2	5/10/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDICTINE LIVING COMMUN	ITY 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).

ITEN	И	DATE	ITEM	DATE	ITEM		DATE
Y4		Y5	Y4	Y5	Y4		Y5
ID Prefix	F0241	Correction	ID Prefix F0282	Correction	ID Prefix	F0309	Correction
Reg. #	483.15(a)	Completed	Reg. #	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. #	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		_
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LSC			LSC		LSC		_
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg.#		Completed	Reg. #	Completed	Reg. #		Completed
LSC			LSC		LSC		_
REVIEWEI		REVIEWED BY (INITIALS) BF/KJ	DATE 05/20/2016	SIGNATURE OF SURVEYOR	10562	DATE 05/	10/2016
REVIEWEI	D ВҮ	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOW U 3/24/2016	IP TO SURVEY CO	DMPLETED ON		ANY UNCORRECTED DEFICIENC ED DEFICIENCIES (CMS-2567) SI			es 🗆 no

POST-CERTIFICATION REVISIT REPORT

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	R / SUPPLI CATION NU				- MAIN BUIL	DING 0	1					DATE OF	F REVISIT
245459			Y1 E	3. Wing							Y2	5/2/2016	6 _{Y3}
NAME OF	FACILITY							STREET	ADDRESS, CIT	Y, STATE, ZIP	CODE		
BENEDIC	CTINE LIV	ING C	COMMUNIT	Y WINSTED				551 FOU	RTH STREET N	IORTH			
						WINSTED, MN 55395							
program, corrected provision	to show the	nose of ate su nd the	deficiencies uch correcti	previously repove ve action was a	orted on the accomplished	CMS-25 d. Each	567, Staten deficiency	nent of De should b	eficiencies and e fully identifie	Plan of Corred using either	ent Amendments ection, that have r the regulation o of each requirem	r LSC	
ITEI	VI			DATE	ITEM				DATE	ITEM			DATE
Y4				Y5	Y4				Y5	Y4			Y5
ID Prefix				Correction	ID Prefix				Correction	ID Prefix			Correction
Reg.#	NFPA 101			Completed	Reg. #	NFPA 1	01		Completed	Reg.#			Completed
LSC	K0027			04/17/2016	LSC	K0062			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
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REVIEWE STATE AG			REVIEWE (INITIALS		DATE 05/20/2	2016	SIGNATUF	RE OF SUF	RVEYOR	34764		DATE 05/0	2/2016
REVIEWE CMS RO	D BY		REVIEWE (INITIALS		DATE		TITLE					DATE	
FOLLOWUP TO SURVEY COMPLETED ON								DEFICIENCIES CMS-2567) SEN			□ vee	:	

3/23/2016

YES NO

		POST	T-CERTIF	ICATION	N REVISIT RE	EPORT			
	R / SUPPLIER / C							DATE O	F REVISIT
IDENTIFIC 245459	CATION NUMBER	A. Building 02 _{Y1} B. Wing	- NEW MAIN EN	NTRANCE			Y2	5/2/201	6 _{Y3}
NAME OF	FACILITY				STREET ADDRESS, CIT	Y, STATE, ZIP CO	DE		
BENEDIC	CTINE LIVING C	OMMUNITY WINSTED			551 FOURTH STREET N	IORTH			
					WINSTED, MN 55395				
program, corrected provision	to show those of and the date su	by a qualified State surver eficiencies previously rep ich corrective action was identification prefix code	oorted on the CM accomplished. E	S-2567, Staten Each deficiency	nent of Deficiencies and should be fully identifie	Plan of Correction dusing either the	on, that have le regulation or	LSC	
ITEN	M	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#	NFPA 101	Completed	Reg. #		Completed	Reg. #			Completed
LSC	K0062	04/13/2016	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
		Correction			Correction				Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
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ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
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LSC			LSC			LSC			
REVIEWEI		REVIEWED BY (INITIALS)	DATE	SIGNATUR	RE OF SURVEYOR	1		DATE	
REVIEWEI	D BY	REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOWU 3/23/2016	JP TO SURVEY C	OMPLETED ON			RRECTED DEFICIENCIES ENCIES (CMS-2567) SEN			YES	s 🔲 no

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: TN48

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AGENCY	I	Facility ID: 00352
MEDICARE/MEDICAID PROVIDER N (L1) 245459 2 STATE VENDOR OR MEDICAID NO.	(1.2) PENTEDICEDIE I HADIC COM					4. TYPE OF ACTION:	2 (L8) 2. Recertification
(L2) 787477100		(L5) WINSTED, N			(L6) 55395	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9) 02/01/2011	NERSHIP	7. PROVIDER/SUI	PPLIER CATEGORY 05 HHA	Y 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other omplaint
6. DATE OF SURVEY 03/24 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 65 (L37) (L38)	65 (L18) 65 (L17) 19 SNF (L39)	B. Not in Com	nce With quirements		And/Or Approved Waivers Of 2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural S 5. Life Safety Code * Code: A1* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	7. Medical Direc	etor
16. STATE SURVEY AGENCY REMARK	KS (IF APPLICABLE S	HOW LTC CANCELL	LATION DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Bruce Melcher	t, HFE NE II	· ·	04/18/2016	(L19)	Kate JohnsTon,	Program Speciali	<u>st</u> 04/20/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE OR SINGLE ST	TATE AGENCY	
DETERMINATION OF ELIGIBILITY			IPLIANCE WITH C	IVIL		nancial Solvency (HCFA-2572) trol Interest Disclosure Stmt (HCFA ve :	A-1513)
22. ORIGINAL DATE OF PARTICIPATION 04/01/1987 (L24)	23. LTC AGREEMI BEGINNING I		24. LTC AGREEME ENDING DATI		26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburse	00 INVOLUNT 05-Fail to M	L30) FARY eet Health/Safety eet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension of B. Rescind Susp	of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	Status Change
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C		(L31)	30. REMARKS		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DAT	ГЕ	Posted 04/26/2016 Co.		
	(L32)			(L33)	DETERMINATION APP	ROVAL	



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Benedictine Living Community Winsted April 7, 2016 Page 4

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

Benedictine Living Community Winsted April 7, 2016 Page 5

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 Benedictine Living Community Winsted April 7, 2016 Page 6

> 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

PRINTED: 04/19/2016 FORM APPROVED OMB NO. 0938-0391

	DI AN OF CORRECTION I IDENTIFICATION NUMBER:		G	(X3) DATE SURVEY COMPLETED	
	245459 B. WI		B. WING _		03/24/2016
	PROVIDER OR SUPPLIER	UNITY WINSTED		STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH WINSTED, MN 55395	0.2
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	INITIAL COMMENT	ΓS	F 00	0	
		rvey was conducted from 6, with surveyors from the nent of Health.			
	as your allegation on Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.			
F 241 SS=D	on-site revisit of you validate that substate regulations has been your verification.	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with	F 24	1	4/21/16
	manner and in an e enhances each res	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.			
	by: Based on observat review, the facility farising and morning (R28) observed for Findings include: R28's quarterly Min	NT is not met as evidenced tion, interview, and document ailed to provide a dignified routine for 1 of 4 residents activities of daily living. imum Data Set (MDS) dated 28 had severe cognitive		R28 is provided with dignity at all risi routines. All residents have the potential to be affected by the same deficient practic ensure full understanding of St. Mary dignity policy a mandatory in service be conducted for all impacted personnel regarding dignity, respect and individuality for a	ce. To 's will
ARORATOR)	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE

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

04/12/2016

Electronically Signed

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:		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	245459		B. WING		03/2	24/2016		
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F 241		age 1 quired total dependence on ty, transferring, dressing, and	F 241	our residents on 4/21/16. This ed will be covered annually and upor				
	personal hygiene. R28's plan of care	dated 1/11/16, identified staff assist with dressing and		orientation as well to ensure on-g compliance. Education will be co by social service designee or des Clinical Manager, DON, and Adm will conduct weekly audits for one and monthly x 3 months to ensure	oing nducted ignee. inistrator month			
	nursing assistant (I room to provide pe personal cares, the on R28, and put he pulled her pants up the knees, but below	on 3/24/16 at 6:59 a.m., NA)-C and NA-D entered R28's rsonal cares. After completing by placed an incontinent brief er pants on while in bed. They so they were just above her ow the incontinent brief. They provers over R28, and left the		is provided. The Quality Council team will and obtained during auditing process determine need of on-going moni and/or protocol enhancements. Administrator/DON will ensure co of POC.	lyze data and toring			
	exiting R28's room in bed at this time,	on 3/24/16, at 7:08 a.m. upon , NA-C stated R28 will remain and staff will assist in getting chair around 8:00 a.m. for						
	R28 in bed on 3/24 sheets and bed spi bedding, and saw I up between her knimaking it difficult for stated, this should would be "undignifi When interviewed NA-C stated staff to down below her individual check if R28 has getting her up in th NA-C stated this w	RN)-E and surveyor observed ./16, at 8:32 a.m., covered with read. RN-E removed R28's R28's with her pants on, pulled ees and incontinent pad, or R28 to move in bed. RN-E not happen, because this ed" for the resident. on 3/24/16, at 12:33 p.m. ypically leave R28's pants continent pad, because they as been incontinent prior to e chair for breakfast. Further, ould be done the same for any up in their wheelchair for meals						

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F 241	director of nursing (ge 2 on 3/24/16, at 2:54 p.m. DON) stated she would teither have their pants pulled	F 24 ⁻			
	all the way up arour completely when in residents to have th	nd the waist or removed bed. It was not acceptable for eir pants down below the above the knees when in				
	A facility policy regarding resident dignity was requested, but none provided. 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN		F 282		4/17/16	
	must be provided by	ed or arranged by the facility y qualified persons in ch resident's written plan of				
	by: Based on observat review, the facility fa plan interventions w residents (R13) revi Findings include: R13's annual Minim 1/9/16, indicated R1	um Data Set (MDS) dated 3 had severe cognitive		The care plan for R13 is currently to followed to ensure that a plate guar 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 edded regarding use of adaptive equipment communication of use and account.	e lucated nt, ability	
	R13's care plan dathad, "Nutrition conc	uired supervision for eating. ed 1/27/16, identified R13 erns Dementia and f m/b [manifested by] need for		for following resident specific care papproaches. Specialized care planned nutrition interventions will be evaluated for a residents and implemented as indicated.	II	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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F 282	Continued From pa	ge 3	F 282				
	care plan directed s with non-skid mat, wher. Tray set up at	t and a therapeutic diet" The staff to, "Provide plate guard with plate- guard arch facing all meals." p.m. R13 was provided		Audits will be conducted weekly for month, and then monthly for three to ensure careplanned nutrition interventions are being met. DON and/or Culinary Director or designees will conduct audits.			
	supper which consi baked beans, and comeal was served or on a green paper powas no plate guard R13 as directed by fork in her left hand baked beans and compared to eat. We will be the support of the su	sted of a salami sandwich, but up watermelon. R13's in a regular plate and placed lacemat in front of her. There or non-skid mat provided to the care plan. R13 held the and attempted to eat the ut up watermelon; however, if the edge of the plate as she when R13 finished her meal, eces of cut up watermelon and		The Quality council committee will data obtained during auditing procedetermine need of on-going monitor and /or protocol enhancements. Administrator will ensure compliance POC	ess and oring		
	culinary service dire guard should be at non-skid mat under	3/24/16, at 12:19 p.m. ector (CSD) stated R13's plate the bottom of her plate, and a R13's plate. This was an plan was not followed.					
	occupational therap have been provided mat under her plate	on 3/24/16, at 3:09 p.m. pist (OT)-A stated R13 should d a plate guard and a non-skid because R13 needed meals mostly due to her, on problems."					
F 309 SS=D	requested, but not p	CARE/SERVICES FOR	F 309			4/21/16	
	Each resident must	receive and the facility must					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
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F 309	or maintain the high mental, and psychological accordance with the and plan of care. This REQUIREMENT	ge 4 ary care and services to attain nest practicable physical, social well-being, in e comprehensive assessment	F3	09			
	review the facility farguidelines for staff in restrictions for 1 of dialysis. Findings include: R21's annual Minimal 11/9/15, indicated Finot not reject any can while eating. The Minimal failure and was treatments.	ion, interview and document iled to provide specific to effectively provide fluid 1 residents (R21) reviewed for turn Data Set (MDS) dated R21 was cognitively intact, did are and needed supervision DS identified a diagnosis of its receiving dialysis			Fluid restrictions are being monitor R74. All residents on fluid restrictions are for same deficient practice The IDT has adjusted facility protoc fluid restriction communication and documentation. The protocol is comprehensive and ensures staff compliance. Mandatory education will be conductulinary director and/or DON or deson 4/21/16. Education will include protocol changes and highlight importance of compliance and repoguidelines. When a resident receive order for fluid restriction: culinary, in	e at risk col for cted by signees orting	
	dated 11/9/15, idenrisk due to an order (cc) of fluid per day have dry lips and mrestrictions and bein CAA further identifie experience thirst ar over fluid requirement address a plan	ified R21 was at nutritional for 1500 cubic centimeters and R21 was observed to outh, related to fluid ag a hemodialysis patient. The ed that the resident may ad may be at risk for going ents. However, the CAA did for R21's fluid restrictions. der Report signed 12/8/15, fluid per day with a start date			order for fluid restriction: culinary, in RD, and resident will collaborate to determine amount of fluids that car consumed at each meal and each sand care plan restriction totals. The totals will be communicated to all sithe tray card system, assignments and E-MAR. Culinary will note fluid restriction on diet tray card system nursing will note fluid restriction on assignment sheets and E-MAR. Fluintakes will be recorded daily at each and upon consumption of fluids throughout the day. Nursing will recorded will recorded to the street of the s	n be shift ese taff via sheets and uid ch meal	

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F 309	identified dietary was confluid restriction a intakes daily to assifluid. The care plan fluid to provide at a R21's hemodialysic identified R21 wen Wednesday and Fa fluid restriction or directed the staff to follow restrictions and addition the care monitor and record the night shift to reflectronic medical identify how much each shift. During observation was served 240 conducts of 720 cc sent for the dinner mea table identified a 1 not provide instruction be served with each on 3/24/16, at 7:03 a lid and straw with water in it was on I could hold 480 cc's was "max 6 cups of the 1500 cc dietary." On 3/24/16, at 7:56	e plan dated 12/12/14, as to provide R21 with a 1500 at meals and to record fluid sure appropriate amounts of a did not identify how much each meal for R21. Is care plan dated 11/30/15, at to the dialysis clinic Monday, ridays. The care plan included a f 1500 cc/24 hours and to remind and encourage R21 to as R21 is often non- compliant. The plan further directed staff to a fluid intake every shift and for cord fluid intake in the record. The care plan did not fluid nursing should provide for a for a fixed to her by the dietary staff. The dietary tray card on the 500 cc fluid restriction but did tion for how much fluid should	F 30	fluids administered during their electronic medical record includ with meals, activities, medicatic supplements. Upon return from unit nursing will review the "Dia Communication Form", and imporders indicated on form as ord MD. The facility will also reques intake while at dialysis which is Dialysis Communication Form. audits will be conducted for one and then monthly for three mor Culinary Director and/or clinical or designees ensuring fluid resitotal are meeting restrictions senephrologist/dialysis unit. Upon identification of non-compliance update the Dialysis unit of non-and educate resident on significance.Quality Council will audits monthly for completion a recommendations.	ling: fluids ins and dialysis ysis blement all ered by it total fluid on the Weekly month ths by managers rictions t by e facility will compliance		

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F 309	total of 720 cc serv for the breakfast m When interviewed aid (DA)-A stated s fluid restrictions we cc a day. DA-A was she was to have at cc at each meal. Sice water for chewi fluid that is provide her of her fluid rest she requested. When interviewed nursing assistant (I kind of restricted w not know what her stated that the aids her room, but no lo The nursing assistat was on fluid restriction intake. Review of R21's Di Record dated 12/2 the dialysis unit to 1500 cc/ daily. Pleamanagement. She since Friday." R21's Dialysis Com 12/26/15, included to facility staff to: "	ee at her table setting for at ed to her by the dietary staff eal. on 3/24/16, at 8:41 a.m. dietary he wasn't sure what R21's re but thought they were 1200 sn't sure on how much fluids each meal, but thinks it is 420 he stated that R21 requests ng,and if she requests more d during the meal we remind rictions and then give her what on 3/24/16, at 12:53 p.m. NA)-B reported that R21 was ith water in her room, but does restrictions were. NA-B further used to track fluid intake in	F 309			

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F 309	2/29/16, included d to facility staff to: "I fluid intake in betwee gains and unable to tx's to help /c [with] When interviewed on the stated that Rifluid restriction and is responsible for doconsumed on the swater in R21's room where it came from her bedside. RN-B any guidance on whore it came from her bedside for fluids or when interviewed on the stated she received knows she is on fluicknow what the restriction been told she drink stated she does not the facility manages what she wants to the facility manages wants the facility manages	imunications Record dated irection from the dialysis unit Please help pt [patient] control een tx's d/t [due to] high fluid of get fluid off. Pt refused extra additional fluid removal." on 3/24/16, at 12:55 p.m. 21 was on 1500 cc per day that the nurse after each shift ocumented the total fluids R21 hift. RN-B observed the cup of and stated she wasn't sure and shouldn't have water at further stated there was not not dietary and nursing are to neach shift. on 3/24/16, at 1:07 p.m. R21 If the cup from dialysis and id restrictions, but does not rictions are exactly and has so too much fluids. R21 further tobtain drinks on her own and so her fluid intake. Staff ask her drink and then they bring it to hight staff fill her ice water for I the water, juice, coffee, ice er she wants at activities. on 3/24/16, at 1:20 p.m. RN-D a 1500 cc fluid restriction and on how much fluids she is Nursing is supposed to e from meals, med passes consumed for each shift but umentation reflects all the	F3	309		

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F 309	director of nursing water glass with a outside the resider to the nurse regard DON stated that number R21 drinks of shift needs to dete she can have on the facility is water she expects staff the drink but provide expecting her fluid. Review of the programment of the programment of the recommended restriction and confluids per day (a cut The assessment in the recommended meal. The assessment in the recommended meal. The assessment in the recommended meal of	on 3/24/16, at 2:20 p.m. the (DON) stated a visual cue of a line drawn through posted ats room lets staff know to talk ding fluid consumption. The curses are to calculate how on their shift and that the next rmine how much more fluid neir shift. The DON stated that sing her fluid intake and that to give R21 what she wants to ducation and reminders restrictions. The property of t	F3	309			

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F 309	cream. The RD fur schedule should be specifics on what I nursing and dietary card should be specific should be specificated that R21 should the season when interviewed culinary services do is nothing specific breakdown betwee CSD stated that or the amount of fluid for R21. After visual verified that the dieta day fluid restriction. When interviewed 12:29 p.m. the dial stated that R21 typic gains averages an kilograms (kg) of the day. RN-A stated the beclosely monit not possibly be addremember the last weight. RN-A state contact with the fact had been following if R21 was following if R21 was following not need as much.	ther stated that a fluid a available to staff with R21 should receive from a each shift and that the dietary ecific regarding how much reved with each meal. The RD ould not have fluids at bedside alt to track everything that R21 e of her activity attendance. on 3/24/16, at 3:06 p.m. the irector (CSD) stated that there documented for fluid restriction en nursing and dietary. The in the dietary card it should state is to be provided at each meal alizing the dietary card the CSD etary card only listed a 1500 cc on. via telephone on 3/24/16, at ysis registered nurse (RN)-A prically comes in high on fluid dietary averages 4 to 4 1/2 eluid are removed on dialysis that R21's fluid restrictions need ored and her restriction could need to as she could not time R21 was at her dry dietary and has been told R21 her fluid restrictions, however given the staff with the staff of the staff	F3	309			

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F 315 SS=D	making it difficult to during her dialysis to during her dialysis to the undated facility indicated "Nursing sprovide for restriction physician." The polistaff along with diet amount of fluids that meal and each shiff fluid restrictions on nursing staff will profor each shift. Large be left at the bedsic 483.25(d) NO CATRRESTORE BLADD Based on the resident who enters indwelling catheter resident's clinical contact catheterization was who is incontinent of treatment and servinfections and to refunction as possible This REQUIREMENT by: Based on observator review, the facility fassess and develop	have this fluid removed reatments. It policy Fluid Restrictions staff and dietary services will ons of fluids upon order of cy further identified " Licensed ary staff will determine at can be consumed at each at. In addition, "dietary will note diet tray card system and ovide additional fluid up to limit equantities of fluids should not le." HETER, PREVENT UTI, ER Lent's comprehensive cility must ensure that a sthe facility without an is not catheterized unless the ondition demonstrates that necessary; and a resident of bladder receives appropriate ces to prevent urinary tract store as much normal bladder existence as much normal bladder existence as much normal bladder in interview and document ailed to comprehensively interventions to promote 2 residents (R19) reviewed for	F 315	The toileting needs of R19 have be assessed, resident specific interventable have been developed and implementable residents have the potential for deficient practice. Facility will review/assess all incontinent residents appropriate Care Plan appropriate continuous designation of the continuous designati	een ntions ented. same	4/17/16

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F 315	R19's quarterly Mi 12/24/15, identified impairment, requir toileting, and was but had never bee since admitted to the quarterly MDS also incontinent of uring program, and the assessment idential. During observation was seated in her eating lunch, and I present about her catheter drainage. During observation was seated in her eating lunch, and I present about her catheter drainage. During observation p.m. R19 was assibathroom by nursip.m. the bathroom wheeled herself of followed R19 out of plastic bag with a sinside. When interviewed stated R19 had be when assisted to the was able to tell stabathroom but staff stated R19 will still toilet, even after be unaware if a format place, "We just take R19's Clinical Documents."	nimum Data Set (MDS) dated d R19 had severe cognitive red extensive assistance with frequently incontinent of urine in trialed on a toileting program the facility. The 9/28/15 or identified, she was frequently re, with no trialed toileting 7/15/15 admission MDS fied R19 had a urinary catheter. In on 3/22/16, at 11:55 a.m. R19 wheelchair in the dining room read a strong odor of urine R19 did not have any visible collection device present. In of care on 3/23/15, at 5:56 isted into a community regulation of the bathroom. NA-A of the bathroom carrying a clear soiled incontinence product on 3/23/16, at 6:02 p.m. NA-A reen incontinent of, "A little" urine the bathroom. At times, R19 ref when she needed to use the figure incontinent, but was all toileting plan for R19 was in the her every 2 hours." umentation assessment dated R19 used an indwelling	F3	aa	are in place and make needed adjustments as indicated by assessments. Bowel and bladder assessments wompleted for new admissions, upon annual review and with significant changes to assess the toileting needli residents. Interventions put into pased on assessment findings. Autorial review and will be completed and bladder assessment was months and will included monitor bowel and bladder assessment was completed, toileting plan is in care and being implemented. Audits will 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 mplement needed changes and determine the need to on-going monitoring/auditing after analysis.	eds of place dits of ted nthly x ing that s plan l be	

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	PROVIDER OR SUPPLIER	UNITY WINSTED		STREET ADDRESS, CITY, STATE, ZIP CO 551 FOURTH STREET NORTH WINSTED, MN 55395		
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F 315	The assessment coon R19's urinary elicon R19's urinary elicon R19's most recent Indwelling Catheter dated 7/4/15, identicatheter, and had not reacheter, and had not reacheter for eliminal been removed and R19 was identified the care plan direct change incontinent hours] and prn [as in R19's medical reconfurther comprehensurinary elimination when R19 had been in place to manage was no indication a had been complete incontinence, historibladder infections,	requently incontinent of bowel. Intained no further information mination. Urinary Incontinence and Care Area Assessment (CAA) fied R19 had an indwelling to urinary incontinence. Red 1/29/16, identified R19 ination d/t [due to] requiring eting." R19 required a Foley tion, however, "[Had] now voiding without concerns." as incontinent of bladder, and ed staff to, "Check and re products q [every] 2 hrs [two needed]." rd was reviewed, and no sive assessments of R19's were identified since 7/22/15, in identified to have a catheter her urinary elimination. There comprehensive assessment d to determine type of ry of urinary incontinence, hydration, medications, mental factors, and was a	F3	15		
	registered nurse (R record and stated F comprehensively as elimination, "Since catheter in place, b					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(X3) DATE COMP	PLETED
		245459	B. WING _		03/2	4/2016
	PROVIDER OR SUPPLIER	JNITY WINSTED		STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH WINSTED, MN 55395		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	order." RN-E stated assessment would risks for incontinent conditions and med their elimination, an assessed for these catheter removed, 'through the cracks. incontinence happed but if she had been for her urinary elimi	t rid of that in pretty short d a comprehensive bladder include review of residents' ce, intake patterns, medical lications which may impair d R19 had never been things since having her [I'm] not sure why she's fallen " RN-E stated most of R19's ned during the night hours, comprehensively assessed nation, a plan could have potentially reduce her	F 31	5		
F 369 SS=D	assess the toileting determine appropria individualized toileti directed staff to ass admission, annual rehanges using the develop "An individual collected data.	identified a purpose, "To needs of all residents and atteness of retraining and / or ng schedules." The policy ress a resident upon reviews or with significant facility assessment tool, and realized care plan" with the VE DEVICES - EATING	F 36	9		4/17/16
	and utensils for resilution. This REQUIREMENT by:	ovide special eating equipment idents who need them. IT is not met as evidenced		P12 has been given a plate giver	and	
	review, the facility	ion, interview and document ailed to ensure adaptive vided for 1 of 1 residents adaptive equipment to		R13 has been given a plate guard non skid place mat for all three mea per care plan. All residents have the potential to b	als as	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		E SURVEY IPLETED
		245459	B. WING _		03/	24/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH WINSTED, MN 55395		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 369	1/9/16, indicated Fimpairment and reimpairment and reimpa	mum Data Set (MDS) dated 13 had severe cognitive quired supervision for eating. Fare Area Assessment (CAA) ntified R13 was independent at the up and adaptive equipment and adaptive equipment and the paraplegia wer half of the body), by swallowing), and nutritional rr, R13 had a current physician ward with non-skid mat, Normal re at edge of table, and glasses e." Intel 1/27/16, identified R13 cerns Dementia and self m/b [manifested by] need for at and a therapeutic diet" The staff to, "Provide plate guard with plate guard arch facing	F 36	affected by same deficient pracresidents with adaptive equipm been reviewed to ensure that treceiving the equipment. Weekly audits will be conducted month and then monthly x 3 urcompliance is fully achieved. For audits will be reviewed at Qual for further recommendations a up. Culinary Director, DON, and designees to monitor.	nent have hey are ed for one ntil Results of ity Council nd/or follow	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245459	B. WING		03	/24/2016
	PROVIDER OR SUPPLIER	UNITY WINSTED		STREET ADDRESS, CITY, STATE, ZIP CO 551 FOURTH STREET NORTH WINSTED, MN 55395		, = 1, = 0.10
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 369	and cut up waterme food off the edge of eat. When R13 fini several pieces of cubaked beans on the During interview on culinary service direguard should be at non-skid mat under error, and the care When interviewed of licensed practical noreceived orders from for a plate guard and stated dietary staff of adaptive equipmeducated on adaptive educated on adaptive resident during daily During interview on occupational therapies commended R13 non-skid mat under needed assistance her, "Cognition and stated she expected followed, and R13 splate guard and nor A facility Adaptive F dated 11/2007, indicated the provided with adapt assessment by the therapies staff." Fur "Nursing staff, toge"	elon, however; R13 spilled the plate as she attempted to shed her meal, she had at up watermelon and several e table. 3/24/16, at 12:19 p.m. ector (CSD) stated R13's plate the bottom of her plate, and a R13's plate. This was an plan was not followed. On 3/24/16, at 2:41 p.m. urse (LPN)-A stated R13 m occupational therapy (OT) and non-skid mat. LPN-A should be following any orders nent for R13, and all staff are we equipment for each	F 3	69		

545902

PRINTED: 04/14/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 245459 B. WING 03/23/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 551 FOURTH STREET NORTH BENEDICTINE LIVING COMMUNITY WINSTED WINSTED, MN 55395 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 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:

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

Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or

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.

Facility ID: 00352

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE_CONSTRUCTION IG 01 - Main Building 01		E SURVEY IPLETED
		245459	B. WING_		03/	23/2016
	PROVIDER OR SUPPLIEF	(4)		STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH WINSTED, MN 55395	76	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	Angela.Kappenma <mailto:angela.ka 01="" 1.="" 2.="" 3.="" a="" actual,="" and="" ber="" building="" co="" con="" consists="" correct="" corridors="" defic="" deficiency="" department="" description="" detection="" facility="" fire="" following="" for="" has="" he="" i(332)="" in="" inf="" is="" mu="" name="" notific<="" of="" or="" p="" plan="" prevent="" prote="" reoccur="" responsible="" sprinkler="" td="" the="" to="" two-stories="" type="" which="" winsted=""><td>estate.mn.us hitney@state.mn.us> and an@state.mn.us appenman@state.mn.us> DRRECTION FOR EACH ST INCLUDE ALL OF THE CORMATION: what has been, or will be, done ciency. proposed, completion date. or title of the person rrection and monitoring to rence of the deficiency medictine Living Community of the original 1960 building. It eight, has no basement, is fully ected, and was determined to be instruction. fire alarm system with smoke pridors and spaces open to the monitored for automatic fire cation. The facility has a of 65 beds and had a census of</td><td>K 00</td><td></td><td></td><td></td></mailto:angela.ka>	estate.mn.us hitney@state.mn.us> and an@state.mn.us appenman@state.mn.us> DRRECTION FOR EACH ST INCLUDE ALL OF THE CORMATION: what has been, or will be, done ciency. proposed, completion date. or title of the person rrection and monitoring to rence of the deficiency medictine Living Community of the original 1960 building. It eight, has no basement, is fully ected, and was determined to be instruction. fire alarm system with smoke pridors and spaces open to the monitored for automatic fire cation. The facility has a of 65 beds and had a census of	K 00			
K 027 SS=D	NOT MET as evid NFPA 101 LIFE S	at 42 CFR, Subpart 483.70(a) is lenced by: AFETY CODE STANDARD smoke barriers have at least a	K 02	27		4/17/16

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	W		JIVID IVO.	0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245459	B. WING_		03/2	23/2016
	PROVIDER OR SUPPLIER	IUNITY WINSTED		STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH WINSTED, MN 55395		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
K 027	10-inch thick solid protective plates the from the bottom of Horizontal sliding of Doors are self-closs accordance with 1 not required to swill latching is not required to swill straight from the solid protective plates the from the bottom of Horizontal sliding of Doors are self-closs accordance with 1 not required to swill switch solid protective plates the from the bottom of Horizontal sliding of Doors are self-closs accordance with 1 not required to swill switch solid protective plates the from the bottom of Horizontal sliding of Doors are self-closs accordance with 1 not required to swill switch such as the from the bottom of Horizontal sliding of Doors are self-closs accordance with 1 not required to swill switch such as the from the bottom of Horizontal sliding of the from the f	ection rating or are at least bonded wood core. Non-rated at do not exceed 48 inches the door are permitted. doors comply with 7.2.1.14. Sing or automatic closing in 9.2.2.2.6. Swinging doors are ng with egress and positive tired. 19.3.7.5, 19.3.7.6, is not met as evidenced by: smoke barriers have at least a ection rating or are at least bonded wood core. Non-rated that do not exceed 48 inches the door are permitted. Hoors comply with 7.2.1.14. Sing or automatic closing in 9.2.2.2.6. Swinging doors are ng with egress and positive tired. 19.3.7.5, 19.3.7.6,	K 02	All smoke barrier doors will be chon a monthly basis for proper closfunctioning. This will be complete Fire Drills are conducted. Documwill be included on the Fire Drill R and results of monthly checks will reviewed at monthly Quality coun meetings. Environmental Director Operations Manager will conduct checks.	sure and d when entation eport l be cil	
K 062 SS=C	8:45am and 11:30a 1) Smoke barrier close when tested This deficiency wa Services Director. NFPA 101 LIFE SA Required automatic continuously mains condition and are	doors by room 108 would not	K 06	2		4/17/16

PRINTED: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		COMPLETED	
	18	245459	B. WING _		03/23/2016	
NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY WINSTED				STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	SHOULD BE COMPLETION	
K 062	Required automatic continuously main condition and are periodically. 19 9.7.5 Findings include: During document between 8:45am 1) Fire Sprinklet 365 days. Currel previous inspecti	is not met as evidenced by: atic sprinkler systems are ntained in reliable operating inspected and tested 0.7.6, 4.6.12, NFPA 13, NFPA 25, tation review on 03/23/2016 and 11:30am, revealed that: r System was not tested within nt annual test was on 06/24/2015 on was 06/12/2014 vas verified by Environmental	K 06	Plant Operations Manager will contracted company (Gilbert Mone month prior to inspection date. will be included on the TELS P Maintenance program. Inspect will be reviewed annually at the council meetings.	echanical) lue date This check reventative ion results	

Facility ID: 00352

5459025

PRINTED: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 02 - NEW MAIN ENTRANCE 245459 B. WING 03/23/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 551 FOURTH STREET NORTH BENEDICTINE LIVING COMMUNITY WINSTED WINSTED, MN 55395 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 **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

Electronically Signed

program participation.

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

TITLE

(X6) DATE 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

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

PRINTED: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR WEDICAR	E & MEDICAID SERVICES				ONID NO	. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG 02 - NEW MAIN ENTRA	ANCE		E SURVEY MPLETED
		245459	B. WING			03	/23/2016
	PROVIDER OR SUPPLIES			STREET ADDRESS, CITY, 551 FOURTH STREET N WINSTED, MN 55395	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTIVE ACTION SHOUTH TO THE APPROPRIET OF THE APPROPRI	ULD BE	(X5) COMPLETIO DATE
K 000	Continued From p	page 1	K 0	00			
	Angela.Kappenma	hitney@state.mn.us> and					
		ORRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION:	×				
	A description of to correct the definition	f what has been, or will be, done ciency.					
	2. The actual, or p	proposed, completion date.					
	responsible for co	or title of the person or call to be a control or call to be a control of the deficiency of the deficiency					
	Winsted was consheight, has no bas	nedictine Living Community structed in 2011, is one-story in sement, is fully fire sprinkler as determined to be of Type on.					
	detection in the co corridors which is department notific	fire alarm system with smoke orridors and spaces open to the monitored for automatic fire cation. The facility has a of 65 beds and had a census of survey.				æ	
K 062 SS=C	NOT MET as evid NFPA 101 LIFE S	AFETY CODE STANDARD	K 0	62			4/13/16
		er systems are continuously able operating condition and are					

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

PRINTED: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES DEPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A, BUILDING 02 - NEW MAIN ENTRANCE			(X3) DATE SURVEY COMPLETED		
		245459	B. WING		03/2	23/2016
	PROVIDER OR SUPPLIER CTINE LIVING COMM	UNITY WINSTED		STREET ADDRESS, CITY, STATE, ZIP C 551 FOURTH STREET NORTH WINSTED, MN 55395	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
K 062	4.6.12, NFPA 13, N This STANDARD i Automatic sprinkle maintained in reliak inspected and teste 4.6.12, NFPA 13, N During documental between 8:45am an 1) Fire Sprinkler S 365 days. Current previous inspection	ed periodically. 18.7.6, 19.7.6, IFPA 25, 9.7.5 s not met as evidenced by: or systems are continuously pole operating condition and are ed periodically. 18.7.6, 19.7.6, IFPA 25, 9.7.5 stion review on 03/23/2016 and 11:30am, revealed that:	KO	Plant Operations Manager sprinkler vendor one month inspection due date and se appointment for annual, tim inspections. The annual check will also the TEL's maintenance pro results of annual checks wi by Quality Council for further recommendations.	prior to t up tely be included on gram and li be reviewed	

Event ID: TN4821



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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.

Benedictine Living Community Winsted April 7, 2016 Page 2

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

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

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

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			SURVEY LETED	
		00352	B. WING		03/2	4/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S RTH STREET	STATE, ZIP CODE		
BENEDIC	CTINE LIVING COMMI	IINII Y WINSTED), MN 55395	Kollin		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficient herein are not corrected shall with a schedule of the Minnesota Department of which the Minnesota of which with a schedule of the Minnesota Department of which will be supported by the Minnesota Department of the M	nether 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.					
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

04/12/16 **Electronically Signed**

TITLE

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED	
		00352	B. WING		03/2	24/2016
	PROVIDER OR SUPPLIER	UNITY WINSTED 551 FOUR	DRESS, CITY, S RTH STREET D, MN 55395	STATE, ZIP CODE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. Is necessary for State enter the word "corrected. You must then State licensure procompletion date, the corrected prior to el Minnesota Department" On 3/22/2016 throu Department's staff the following corrected prior to electronic period the following correction that you and identify the date	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be ectronically submitting to the	2 302			3/25/16
	DISORDER TRAIN MN St. Statute 144. (a) If a nursing facil Alzheimer's disease or related of segregated or generated and their supervisor care. (b) Areas of require (1) an explanation of related disorders; (2) assistance with	EASE OR RELATED ING: .6503 ity serves persons with disorders, whether in a eral unit, the facility's direct ers must be trained in dementia d training include: of Alzheimer's disease and activities of daily living; with challenging behaviors;				

Minnesota Department of Health

STATE FORM 6899 TN4811 If continuation sheet 2 of 24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DA CO			
		00352	B. WING		03/	24/2016
	PROVIDER OR SUPPLIER	UNITY WINSTED 551 FG	TADDRESS, CITY, DURTH STREET FED, MN 55395	T NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 302	(c) The facility shall written or electronic training program, the trained, the frequent topics covered. (d) The facility shall this section. This MN Requirement by: Based on interview facility failed to ensurate family were provided frequency staff recentraining. This had to current and future of the interested per staff include: A review of staff training include: A review of staff training care to recourse descriptions to include: an introduct and dementia; compliving; and behavior facility provided door staff received dementations was required the reafter, with a "Dange of the facility packet, given to reserved."	provide to consumers in a form a description of the se categories of employees acy of training, and the basic document compliance with ent is not met as evidenced and document review, the sure residents and interested dinformation regarding the sived Alzheimer's dementia he potential to affect all esidents of the facility and	at of s se y	Corrected		
	In an interview on 3	3/24/2016 at 1:39 p.m. the				

Minnesota Department of Health STATE FORM

RM 6899 TN4811 If continuation sheet 3 of 24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			D WING			
		00352	B. WING		03/2	4/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BENEDIO	CTINE LIVING COMM	IINITY WINSTED	TH STREET , MN 55395	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 302	social services des admission packet p not provide" informa of dementia training stated sheet "defini adjusted to meet the In an interview on 3 facility administrato admission package but acknowledged training was not dis SUGGESTED MET The administrator of process to ensure: completed by both staff; and residents made aware that design and packet process.	ignee (SS) stated the provided to consumers "does ation regarding the frequency grovided to the staff. The SS tely can be tweaked" and e requirements. 2/24/2016 at 3:55 p.m., the r stated she thought the information "was adequate," the frequency of the staff	2 302			
2 565	TIME PERIOD FOR (21) days. MN Rule 4658.0409 Plan of Care; Use Subp. 3. Use. A comust be used by all care of the resident	cription of the training topics. R CORRECTION: Twenty-one Subp. 3 Comprehensive Comprehensive plan of care I personnel involved in the comprehensive plan of care I personnel involved in the comprehensive plan of care I personnel involved in the comprehensive plan of care I personnel involved in the comprehensive plan of care I personnel involved in the comprehensive plan of care I personnel involved in the comprehensive plan of care	2 565			4/17/16
	by:	on, interview and document		Corrected		

Minnesota Department of Health

STATE FORM 6899 TN4811 If continuation sheet 4 of 24

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00050	B. WING		00/0	4/0046
		00352			03/2	4/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BENEDI	CTINE LIVING COMM	IINII V WINSTED	RTH STREET), MN 55395			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ige 4	2 565			
	review, the facility failed to ensure nutritional care plan interventions were followed for 1 of 1 residents (R13) reviewed for nutrition.					
	Findings include:					
	1/9/16, indicated R	num Data Set (MDS) dated 13 had severe cognitive quired supervision for eating.				
	had, "Nutrition cond difficulty feeding se adaptive equipmen care plan directed s	ted 1/27/16, identified R13 cerns Dementia and If m/b [manifested by] need for t and a therapeutic diet" The staff to, "Provide plate guard with plate- guard arch facing all meals."				
	supper which consibaked beans, and of meal was served or on a green paper p was no plate guard R13 as directed by fork in her left hand baked beans and cR13 spilled food of attempted to eat. With the several pies several baked bear During interview on	3/24/16, at 12:19 p.m.				
	guard should be at non-skid mat under error, and the care	ector (CSD) stated R13's plate the bottom of her plate, and a r R13's plate. This was an plan was not followed.				
		on 3/24/16, at 3:09 p.m. bist (OT)-A stated R13 should				

Minnesota Department of Health

STATE FORM 6899 TN4811 If continuation sheet 5 of 24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		00352	B. WING		03/2	24/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BENEDIC	CTINE LIVING COMM	IINITY WINSTED	RTH STREET , MN 55395	NORTH		
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From page 5		2 565			
	mat under her plate assistance with her "Cognition and vision	esident care plans was				
	The director of nurs review and revise p to ensuring the care resident is followed designee could devand develop a mon are providing care a of care.	THOD OF CORRECTION: sing (DON) or designee could solicies and procedures related e plan for each individual. The director of nursing or relop a system to educate staff itoring system to ensure staff as directed by the written plan				
2 830	MN Rule 4658.0520 Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 830			4/17/16

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. , ,	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED		
		00352	B. WING		03/2	4/2016
	PROVIDER OR SUPPLIER	INITY WINSTED 551 FC	ADDRESS, CITY, URTH STREE ED, MN 55395			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 6	2 830			
	by: Based on observati review the facility fa guidelines for staff t	ent is not met as evidenced on, interview and document illed to provide specific to effectively provide fluid 1 residents (R21) reviewed	or	Corrected		
	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.		d			
			ne			
		der Report signed 12/8/15, fluid per day with a start dat	9			
	identified dietary wa cc fluid restriction a intakes daily to assi	plan dated 12/12/14, as to provide R21 with a 150 t meals and to record fluid ure appropriate amounts of did not identify how much ach meal for R21.				

6899

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00352	B. WING		03/2	4/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 55.	.,
BENEDI	CTINE LIVING COMM	IINITY WINSTED	RTH STREET , MN 55395	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	R21's hemodialysis identified R21 went Wednesday and Fr a fluid restriction of directed the staff to follow restrictions a In addition the care monitor and record the night shift to recelectronic medical ridentify how much feach shift. During observation was served 240 cc's and 240 cc's of coff total of 720 cc serv for the dinner meal table identified a 15 not provide instruct be served with each on 3/24/16, at 7:03 a lid and straw with water in it was on F could hold 480 cc's was "max 6 cups p the 1500 cc dietary on 3/24/16, at 7:58 dietary staff 240 cc and 240 cc of coffe total of 720 cc serv for the breakfast m	care plan dated 11/30/15, to the dialysis clinic Monday, idays. The care plan included 1500 cc/24 hours and remind and encourage R21 to s R21 is often non- compliant. plan further directed staff to fluid intake every shift and for cord fluid intake in the eccord. The care plan did not fluid nursing should provide for on 3/23/16, at 5:11 p.m. R21 s of ice water, 240 cc's of juice fee at her table setting for at ed to her by the dietary staff. The dietary tray card on the 500 cc fluid restriction but did ion for how much fluid should in meal. a.m. a clear water glass with approximately 360 cc's of R21's bedside table. The cup. Written on the lid of the glass er day." This was in addition to was providing for R21. a.m. R21 was served by of ice water, 240 cc of juice e at her table setting for at ed to her by the dietary staff	2 830			

Minnesota Department of Health

STATE FORM 6899 TN4811 If continuation sheet 8 of 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		00352	B. WING		03/	24/2016
	PROVIDER OR SUPPLIER	UNITY WINSTED 551 FOUR	DRESS, CITY, S RTH STREET , MN 55395	STATE, ZIP CODE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	cc at each meal. Shice water for chewir fluid that is provided her of her fluid restricted with the fluid restricted with the fluid restricted the fluid restricted was on fluid restricted the fluid restriction intake. Review of R21's Direct Record dated 12/21 the dialysis unit to f 1500 cc/ daily. Plear management. She since Friday." R21's Dialysis Com 12/26/15, included to facility staff to: ""	ne stated that R21 requests ng, and if she requests more d during the meal we remind rictions and then give her what on 3/24/16, at 12:53 p.m. NA)-B reported that R21 was ith water in her room, but does restrictions were. NA-B further used to track fluid intake in	2 830			
	2/29/16, included d to facility staff to: "I fluid intake in betwee gains and unable to tx's to help /c [with] When interviewed of	imunications Record dated irection from the dialysis unit Please help pt [patient] control een tx's d/t [due to] high fluid o get fluid off. Pt refused extra additional fluid removal." on 3/24/16, at 12:55 p.m. 21 was on 1500 cc per day				

6899

Minnesota Department of Health
STATE FORM

TN4811 If continuation sheet 9 of 24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00352		B. WING		03/2	24/2016
NAME OF	PROVIDER OR SUPPLIER	Sī	TREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE LIVING COMM	JNITY WINSTED		TH STREET , MN 55395	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF THE APPR	ULD BE	(X5) COMPLETE DATE
2 830	fluid restriction and is responsible for do consumed on the swater in R21's room where it came from her bedside. RN-B any guidance on whorovide for fluids or When interviewed of stated she received knows she is on fluid know what the restribeen told she drink stated she does not the facility manages what she wants to the facility manages what she wants to the rand receives all cream and whatever When interviewed of stated R21 was on has been educated supposed to have. document the intak and any other fluid isn't sure if the door fluids she drinks or When interviewed of director of nursing (water glass with a life outside the resident to the nurse regard DON stated that numuch R21 drinks or shift needs to deter she can have on the	that the nurse after each ocumented the total fluid hift. RN-B observed them and stated she wasn't and shouldn't have was further stated there was not dietary and nursing an each shift. In 3/24/16, at 1:07 p.m. If the cup from dialysis and restrictions, but does rictions are exactly and is too much fluids. R21 for the total drinks on her oward the water, juice, coffee or she wants at activities on 3/24/16, at 1:20 p.m. a 1500 cc fluid restriction on how much fluids shown with the water, juice, coffee or she wants at activities on 3/24/16, at 1:20 p.m. a 1500 cc fluid restriction on how much fluids shown with the water, juice, coffee or she wants at activities on some much fluids shown with the water supposed to the from meals, med passed to the form meals, med passed to the	ds R21 cup of sure ter at anot are to R21 and not has further wn and ask her g it to er for e, ice s. RN-D on and e is ses t but he ue of a ed to talk he w next luid ed that	2 830			

Minnesota Department of Health

STATE FORM 6899 TN4811 If continuation sheet 10 of 24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00352		B. WING		03/	24/2016
	PROVIDER OR SUPPLIER	UNITY WINSTED	551 FOUR	DRESS, CITY, S RTH STREET D, MN 55395			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORM.	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 830	she expects staff to drink but provide expeding her fluid in Review of the progracions occasions when shifluid. R21's quarterly nutraction and constituids per day (a cup The assessment id the recommended in meal. The assessment id the recommended no coprovided diet educate referrals were indicated for the interviewed was a stated that R21 was with her fluid restriction fluid gains all year. On how R21 was not she drinks too man cream. The RD furt schedule should be specifics on what R nursing and dietary card should be ser stated that R21 should be ser stated that R21 should be caused that R21 should be caused that R21 should be ser stated that R21 should be caused that R21 should be	o give R21 what she ducation and remind restrictions. Tess notes from Nov 6, identified R21 had e consumed over 15 wittion assessment data 1500 cc flowers greater than 8 p is approximately 1 entified fluid gains wange and drinks 36 ment further indicated fluid restrictions and thanges as R21 had attion with little succe	ember diseveral 500 cc of ated uid 5 cups of 90 cc). Vere above 0 cc per di R21 was dibeen ss. No 4/16, at in (RD) compliant battling e specific distate that id eats ice di the form the dietary much at bedside in that R21 dance.	2 830			
		rector (CSD) stated					

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00352		B. WING		03/	24/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BENEDIO	CTINE LIVING COMMI	JNITY WINSTED		TH STREET	NORTH		
DENEDIO			WINSTED	, MN 55395			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 11		2 830			
	breakdown between CSD stated that on the amount of fluids for R21. After visua	documented for fluid ren nursing and dietary. The dietary card it shows to be provided at each lizing the dietary card stary card only listed and n.	The uld state h meal the CSD				
	12:29 p.m. the dialy stated that R21 typi gains averages and kilograms (kg) of fl day. RN-A stated th to be closely monito not possibly be adh remember the last tweight. RN-A stated contact with the fac had been following	ria telephone on 3/24/1 rsis registered nurse (Fically comes in high on I averages 4 to 4 1/2 uid are removed on diat R21's fluid restriction and her restriction ered to as she could not me R21 was at her diat that dialysis has been told her fluid restrictions, higher restrictions she would removed.	RN)-A alysis alysis as need a could of y a in R21 owever				
	because of renal fa consistently providing fluid consumption w	on a 1500 fluid restricti ilure, the facility was non ng and monitoring all co which has caused fluid have this fluid remove reatments.	ot of R21's gains				
	indicated "Nursing s provide for restriction physician." The polistaff along with diet amount of fluids that meal and each shift fluid restrictions on nursing staff will pro-	policy Fluid Restriction staff and dietary service ons of fluids upon order cy further identified "Lary staff will determine at can be consumed at a line and ition, "dietary with tray card system a poide additional fluid upe quantities of fluids shoulds."	es will or of cicensed e ceach will note and o to limit				

Minnesota Department of Health

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00352	B. WING		03/2	4/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BENEDIC	CTINE LIVING COMM	UNITY WINSTED	RTH STREET D, MN 55395			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 12	2 830			
	be left at the bedsic	de."				
	The director of nurs and revise policies and intake monitori education related to receive dialysis trea or designee could of appropriate, timely monitoring is provide	THOD OF CORRECTION: sing, or designee, could review and procedures related to fluid ng, and provide staff to the care of residents who atment. The director of nursing develop an audit tool to ensure and comprehensive fluid ded. R CORRECTION: Twenty-one	1			
2 910	MN Rule 4658.0529 Incontinence	5 Subp. 5 A.B Rehab -	2 910			4/17/16
	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.					
	by:	ent is not met as evidenced ion, interview and document		Corrected		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00352	B. WING		03/	24/2016
	PROVIDER OR SUPPLIER	INITY WINSTED 551 FC	ADDRESS, CITY, SOURTH STREET ED, MN 55395			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
2 910	review, the facility fassess and develop continence for 1 of urinary incontinence. Findings include: R19's quarterly Min 12/24/15, identified impairment, require toileting, and was frout had never been since admitted to the quarterly MDS also incontinent of urine program, and the 7 assessment identification was seated in her weating lunch, and hapresent about her catheter drainage of During observation p.m. R19 was assist bathroom by nursin p.m. the bathroom wheeled herself out followed R19 out of plastic bag with a stinside.	ailed to comprehensively of interventions to promote 2 residents (R19) reviewed fee. imum Data Set (MDS) dated R19 had severe cognitive and extensive assistance with equently incontinent of urine trialed on a toileting programe facility. The 9/28/15 identified, she was frequent, with no trialed toileting with no trialed toileting and R19 had a urinary cathet on 3/22/16, at 11:55 a.m. Revieelchair in the dining room and a strong odor of urine R19 did not have any visible ollection device present. of care on 3/23/15, at 5:56 ated into a community grassistant (NA)-A. At 6:00 door was opened, and R19 at the bathroom carrying a cleotiled incontinence product	d en ly er. 19			
	stated R19 had bee when assisted to th was able to tell staf bathroom but staff, stated R19 will still	on 3/23/16, at 6:02 p.m. NA- en incontinent of, "A little" uring e bathroom. At times, R19 f when she needed to use th "Have to ask her a lot." NA- void after being assisted to the ing incontinent, but was	ne le ·A			

Minnesota Department of Health

STATE FORM 6899 TN4811 If continuation sheet 14 of 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00352		B. WING		03/	24/2016
	PROVIDER OR SUPPLIER	UNITY WINSTED	551 FOUR	DRESS, CITY, S RTH STREET , MN 55395	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 910	unaware if a formal place, "We just take R19's Clinical Docu 7/22/15, identified F catheter, and was f The assessment co on R19's urinary eli R19's most recent Indwelling Catheter dated 7/4/15, identicatheter, and had not reached the care plan dathad, "Impaired elimassistance with toile catheter for eliminal been removed and R19 was identified at the care plan direct change incontinent hours] and prn [as not reconstructed by the comprehension when R19 had been in place to manage was no indication a had been complete incontinence, historibladder infections, behaviors, environmy voiding pattern iden.	toileting plan for R1 her every 2 hours. It her every 1 her every 2 hours. It her every 2 hours 1 her every 1 her every 2 her every 1 her every 2 her every 3 her every 6 urinary incontinents of black 2 her every 1 her every 1 her every 2 her every 3 her every 6 urinary elimination 2 her every	ent dated ng t of bowel. Information and nent (CAA) welling ce. d R19 equiring I a Foley I now cerns." dder, and and 2 hrs [two d no R19's 7/22/15, a catheter ion. There essment of ence, ns, vas a m.	2 910			
	registered nurse (R record and stated F	N)-E reviewed R19's R19 had not been	s medical				

Minnesota Department of Health STATE FORM

TN4811 If continuation sheet 15 of 24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00352	B. WING		03/2	24/2016
	PROVIDER OR SUPPLIER	UNITY WINSTED 551 FOUR	DRESS, CITY, S RTH STREET , MN 55395	STATE, ZIP CODE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 910	comprehensively as elimination, "Since catheter in place, by discontinued shortly year prior, "[We] go order." RN-E stated assessment would risks for incontinent conditions and meditheir elimination, and assessed for these catheter removed, 'through the cracks. incontinence happed but if she had been for her urinary eliming been developed to incontinence. An undated facility of Assessment policy assess the toileting determine approprising dividualized toileting directed staff to assess admission, annual of changes using the findevelop "An individual collected data. SUGGESTED MET The director of nursiand revise policies monitoring and provide staff coresidents with urinal of nursing or design	ssessed for urinary last June" when she had a ut R19's catheter had been after admission nearly one trid of that in pretty short da comprehensive bladder include review of residents' ce, intake patterns, medical lications which may impair d R19 had never been things since having her "[I'm] not sure why she's fallen "RN-E stated most of R19's ened during the night hours, comprehensively assessed nation, a plan could have potentially reduce her Bowel and Bladder identified a purpose, "To needs of all residents and atteness of retraining and / or ng schedules." The policy sess a resident upon reviews or with significant facility assessment tool, and utalized care plan" with the	2 910			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00352	B. WING		03/2	4/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BENEDIC	CTINE LIVING COMMI	INITY WINSTED	RTH STREET , MN 55395			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 16	2 910			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 945	MN Rule 4658.0530 Subp. 1 Assistance with Eating - Nursing Personnel		2 945			4/17/16
	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.					
	by: Based on observati review, the facility fa equipment was pro-	ent is not met as evidenced on, interview and document ailed to ensure adaptive vided for 1 of 1 residents adaptive equipment to nce with eating.		Corrected		
	Findings include:					
	R13's annual Minim	um Data Set (MDS) dated				

6899

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00352	B. WING		03/2	24/2016
	PROVIDER OR SUPPLIER	INITY WINSTED 551 FOUR	DRESS, CITY, S RTH STREET , MN 55395	STATE, ZIP CODE NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 945	1/9/16, indicated Rimpairment and required R13's Nutritional Cadated 1/14/16, iden meals after tray set was provided. R13's Physician Ordidentified R13 had of (paralysis of the low dysphagia (difficulty deficiency. Further order for, "Plate guautensils, place plate directly above plate R13's care plan dathad, "Nutrition condifficulty feeding seadaptive equipment care plan directed swith non-skid mat wher. Tray set up at During observation was provided supposandwich, baked be R13's meal was serplaced on a green provided to R13 as orders and care plateft hand and attem and cut up watermet food off the edge of eat. When R13 fini	Is had severe cognitive uired supervision for eating. The Area Assessment (CAA) tified R13 was independent at up and adaptive equipment of the body), which was a current physician and with non-skid mat, Normal at edge of table, and glasses." The ed 1/27/16, identified R13 terns Dementia and lif m/b [manifested by] need for the and a therapeutic diet" The staff to, "Provide plate guard with plate guard arch facing all meals." The estaff to, "Provide plate guard with plate guard arch facing all meals." The staff to, "Provide plate guard with plate guard arch facing all meals." The staff to, "Provide plate guard with plate guard arch facing all meals." The staff to, "Provide plate guard with plate guard arch facing all meals." The staff to, "Provide plate guard with plate guard arch facing all meals." The staff to, "Provide plate guard with plate guard arch facing all meals." The staff to, "Provide plate guard with plate guard arch facing all meals." The staff to, "Provide plate guard with plate and be and the plate and the plate and the plate and the plate as she attempted to shed her meal, she had ut up watermelon and several and the plate as she attempted to shed her meal, she had ut up watermelon and several and the plate as she attempted to shed her meal, she had ut up watermelon and several and the plate as she attempted to shed her meal, she had ut up watermelon and several and the plate as she attempted to shed her meal, she had ut up watermelon and several and the plate as she attempted to she had ut up watermelon and several and the plate as she attempted to she had ut up watermelon and several and the plate as she attempted to she had ut up watermelon and several and the plate as she attempted to she had ut up watermelon and several and the plate as she attempted to she had ut up watermelon and several and the plate as she attempted to she had ut up watermelon and several and the plate as she attempted to she had ut up watermelon and several and the plate as she attempted to she had ut u	2 945			

6899

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00352	B. WING		03/2	4/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	03/2	7/2010
		551 FOUR	TH STREET	•		
BENEDIC	CTINE LIVING COMM	UNITY WINSTED	, MN 55395			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 945	Continued From pa	ge 18	2 945			
2 343	During interview on culinary service direguard should be at non-skid mat under error, and the care When interviewed olicensed practical nreceived orders from for a plate guard and stated dietary staff of adaptive equipmeducated on adaptive resident during daily During interview on occupational therap recommended R13 non-skid mat under	3/24/16, at 12:19 p.m. ector (CSD) stated R13's plate the bottom of her plate, and a R13's plate. This was an plan was not followed. on 3/24/16, at 2:41 p.m. urse (LPN)-A stated R13 m occupational therapy (OT) and non-skid mat. LPN-A should be following any orders nent for R13, and all staff are we equipment for each	2 343			
	stated she expected followed, and R13 stated guard and nor A facility Adaptive F dated 11/2007, indicated with adapt assessment by the therapies staff." Further following for the following staff.	vision problems." OT-A d OT recommendations to be should have been provided a n-skid mat as directed. reeding Equipment policy cated, "Residents will be tive feeding equipment upon licensed nursing and arther, the policy directed,				
	suggested metal suggested and revise policies assistance with eatirelated to the care of devices to promote of nursing or design	ther with Dietary, will see that allable during mealtimes." THOD OF CORRECTION: Sing, or designee, could review and procedures related to sing and provide staff education of residents who use assistive independence. The director nee could develop an audit tool attended to appropriate assistance and				

Minnesota Department of Health

STATE FORM 6899 TN4811 If continuation sheet 19 of 24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			B. WING		00/0	
		00352			03/2	4/2016
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S RTH STREET	STATE, ZIP CODE		
BENEDIC	CTINE LIVING COMM	IINITY WINSTED	, MN 55395			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 945	Continued From pa	ge 19	2 945			
	equipment are provided to promote resident independence.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21426		A.04 Subd. 3 Tuberculosis	21426			4/17/16
	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.					
	by: Based on interview facility failed to ens tuberculin skin test 5 employees (RN-F	and document review, the ure a required two step (TST) was completed for 3 of F, NA-E, and NA-F), and a g was completed for 1 of 5		Corrected		

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00352		B. WING		03/	24/2016
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
BENEDI	CTINE LIVING COMM	UNITY WINSTED		RTH STREET , MN 55395	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
	Continued From paremployees (NA-F). have a completed F Assessment Works Licensed by the Mir Findings include: Registered nurse (F (Tuberculosis) Test 11/11/14/15, identification negative. However identify millimeters Nursing assistant (N (Tuberculosis) Test 2/16/16, identified z the documentation negative or positive NA-F's Mantoux (Tuundated, identified completed, and no completed. When interviewed director of nursing (assessment was just the facility, as she wassessment. Facility policy titled dated 12/9/11, identification and r for health care works.	ge 20 Further, the facility for acility Tuberculosis (sheet for Health Carennesota Department) RN)-F's Mantoux Form dated 11/2/15, ed both TST tests to (the documentation (mm) of induration. NA)-E's Mantoux Form dated 1/27/16, etcomm induration. Induration did not identify if the common first or second TS (the symptom screening to mail to make the completed on 3/24 (the symptom screening to mail to make the completed on 3/24 (the symptom screening to mail to make the murse will	failed to (TB) Risk Settings of Health. and be did not and However, test was m. Tr were was m. risk 1/16, for a current cedure" leasure ening tool	21426			
	The director of nurs	THOD OF CORRECT sing or designee coul s to ensure TB testin dents is documented	d review g for				

Minnesota Department of Health

STATE FORM 6899 TN4811 If continuation sheet 21 of 24

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00352	B. WING	·····	03/2	4/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BENEDIC	CTINE LIVING COMM	UNITY WINSTED	RTH STREET), MN 55395	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426 21805	their policy to ensur the interpretations of as per the recommed Disease Control (C re-educated on new revisions. An audit developed and revi- assessment and as TIME PERIOD FOR (21) days	alle. They could also revise re millimeters of induration and of the results are documented endations of the Centers for DC). Nursing staff could be we processes and policy ing system could be ewed by the facility's quality ssurance committee. R CORRECTION: Twenty-one	21426			4/17/16
	Residents of HC Fa Subd. 5. Courteouresidents have the courtesy and respe employees of or pe health care facility. This MN Requirements by: Based on observation review, the facility for facility for facility for facility for facility for facility for findings include: R28's quarterly Min 1/7/16, identified R2 impairment, and reconstructions.			Corrected		
	R28's plan of care of	dated 1/11/16, identified staff				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
		00352	B. WING		03/2	24/2016			
NAME OF I	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION SHOULD BE COMPLETE THE APPROPRIATE DATE				
21805	Continued From pa	age 22	21805						
	are to provide total grooming.	assist with dressing and							
	nursing assistant (Normal room to provide personal cares, the on R28, and put he pulled her pants up the knees, but belo	on 3/24/16 at 6:59 a.m., NA)-C and NA-D entered R28 rsonal cares. After completing placed an incontinent brief or pants on while in bed. They also so they were just above her by the incontinent brief. They also covers over R28, and left the							
	exiting R28's room, in bed at this time,	on 3/24/16, at 7:08 a.m. upor, NA-C stated R28 will remair and staff will assist in getting thair around 8:00 a.m. for							
	R28 in bed on 3/24 sheets and bed spr bedding, and saw Fup between her known making it difficult for stated, this should would be "undignificult when interviewed on NA-C stated staff ty down below her including will check if R28 has sheets and bed say to be sheet and staff ty down below her including the same staff ty down below her including the same sheets and say the same staff ty down below her including the same says the same s	RN)-E and surveyor observed /16, at 8:32 a.m., covered with read. RN-E removed R28's R28's with her pants on, pulled ees and incontinent pad, or R28 to move in bed. RN-E not happen, because this ed" for the resident. on 3/24/16, at 12:33 p.m. aypically leave R28's pants continent pad, because they as been incontinent prior to e chair for breakfast.	h						
	director of nursing expect that residen all the way up arou completely when in residents to have the	on 3/24/16, at 2:54 p.m. (DON) stated she would at either have their pants pulled and the waist or removed a bed. It was not acceptable from the pants down below the dispose the knees when in							

Minnesota Department of Health

STATE FORM 6899 TN4811 If continuation sheet 23 of 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
		00352	B. WING		03/2	4/2016				
NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY WINSTED STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH WINSTED, MN 55395										
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE				
21805	bed. A facility policy regarequested, but none SUGGESTED MET The director of nurs and revise policies dignity and provisio education to reinfor care. The director of develop an audit to timely and dignified	urding resident dignity was	21805							

6899