### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

					ND TRANSMITTAL E SURVEY AGENCY	ID: TP05 Facility ID: 00314
1. MEDICARE/MEDICAID PROVIDER NO.           (L1)         245360           2.STATE VENDOR OR MEDICAID NO.         (L2)         448348100	D.	3. NAME AND ADI (L3) <b>BENEDIC</b> (L4) <b>100 GLEN</b> (L5) <b>NEW LO</b>	TINE LIVINO OAKS DRIV	G COM	MUNITY OF NEW LOND (L©6273	1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint
<ol> <li>5. EFFECTIVE DATE CHANGE OF OWN (L9) 02/01/2011</li> </ol>	VERSHIP	7. PROVIDER/SUP 01 Hospital		09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
	<b>3/2014</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IIE 12 RHC	14 CORF	FISCAL YEAR ENDING DATE: (L35) 12/31
<ul> <li>11LTC PERIOD OF CERTIFICATION</li> <li>From (a): To (b):</li> <li>12. Total Facility Beds</li> <li>13. Total Certified Beds</li> <li>14. LTC CERTIFIED BED BREAKDOWN</li> </ul>	62 (L18) 62 <sup>(L17)</sup>	B. Not in Comp	ce With quirements	aivers:	And/Or Approved Waivers Of The2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF)5. Life Safety Code * Code: A1* 15. FACILITY MEETS	<u>Following Requirements:</u> 6. Scope of Services Limit7. Medical Director8. Patient Room Size9. Beds/Room (L12)
18 SNF 18/19 SNF 62 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARK See Attached Remarks      17. SURVEYOR SIGNATURE	、 	Date :			18. STATE SURVEY AGENCY APP	
Tim Rhonemus, H			4/17/2014	(L19)	Kate JohnsTon, Enfor	(L20)
<ol> <li>DETERMINATION OF ELIGIBILITY</li> <li>X_1. Facility is Eligible to Part</li> <li>2. Facility is not Eligible</li> </ol>		20. COM	PLIANCE WITH CF TS ACT:		21. 1. Statement of Financia	
22. ORIGINAL DATE OF PARTICIPATION 11/01/1986	23. LTC AGREEMI BEGINNING I		4. LTC AGREEMEN ENDING DATE		26. TERMINATION ACTION: <u>VOLUNTARY</u> 00     01-Merger, Closure     02-Dissatisfaction W/ Reimbursement	05-Fail to Meet Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVE A. Suspension of B. Rescind Susp	of Admissions:	(L25) (L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	t 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active
28. TERMINATION DATE:	29	. INTERMEDIARY/C	(L45)		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32 (L32)	DETERMINATION C 04/07/2014	if Approval DATI	E (L33)	DETERMINATION APPROV	VAL

CENTERS FOR MEDICARE & MEDICAID SERVICES MITTAL ID: TP05

Facility ID: 00314

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

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

Page 2 Provider Number: 24- 5360 Item 16 Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective March 21, 2014, the facility is certified for 62 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245360

April 30, 2014

Mr. James Laine, Administrator Benedictine Living Community Of New London 100 Glen Oaks Drive New London, Minnesota 56273

Dear Mr. Laine:

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 March 21, 2013, the above facility is certified for:

62 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 62 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Inston

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

April 17, 2014

Mr. James Laine, Administrator Benedictine Living Community Of New London 100 Glen Oaks Drive New London, MN 56273

RE: Project Number S5360025

Dear Mr. Laine:

On February 21, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 5, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 3, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 10, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 5, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 21, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 5, 2014, effective March 21, 2014 and therefore remedies outlined in our letter to you dated February 21, 2014, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245360	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 4/3/2014		
Name of Facility			Street Address, City, State, Zip Code			
BENEDICTINE LIVING COMMUNITY OF NEW LONDON			100 GLEN OAKS DRIVE NEW LONDON, MN 56273			

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

(Y4)	Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	ltem		(Y5)	Date
				Correction					Correction					Correction
1	) Prefix	F0225		Completed 03/06/2014		ID Prefix	F0226		Completed 03/06/2014		ID Prefix	F0279		Completed 03/01/2014
		483.13(c)(1)(ii)	(iii) (c)(2)	-			483.13(c)					483.20(d), 483.2	0(k)(1)	
	LSC	403.13(0)(1)(1)	-(111), (C)(Z) -	(+)		LSC	403.13(0)		-		LSC	403.20(u), 403.2	U(K)(T)	
					1									
				Correction					Correction					Correction
II	) Prefix	F0315		Completed 03/05/2014		ID Prefix	F0323		Completed 03/05/2014		ID Prefix	F0356		Completed 02/07/2014
		483.25(d)		-			483.25(h)		-			483.30(e)		
	LSC					LSC								
				Correction					Correction					Correction
II	D Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
	Reg. #					Reg. #					Reg. #			
	LSC					LSC					LSC			
				<b>a</b>					<b>a</b>					<b>0</b> //
				Correction Completed					Correction Completed					Correction Completed
II	O Prefix					ID Prefix			-		ID Prefix			
	Reg. #					Reg. #			_		Reg. #			
	LSC					LSC			-		LSC			
				Correction					Correction					Correction
				Completed					Completed					Completed
II	D Prefix					ID Prefix			-		ID Prefix			
	Reg. # LSC					Reg. #			-		Reg. #			
	200													
Revi	ewed By		Reviewed E	Зу	Da	te:	Signature	of Surve	yor:				Date:	
State	Agency	/		BF/KJ	4	4/18/20	14		2079	4			4/3	3/2014
Revi	ewed By	,	Reviewed E	Зу	Da	te:	Signature	of Surve	yor:				Date:	
CMS	RO													
Foll	owup to	Survey Comple						-				a Summary of		
		2/5/2	014				Un	correcte	a Deficiencie	5 (CM	5-2567) Sent	to the Facility?	YES	NO

### State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00314	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 4/3/2014		
Name of Facility			Street Address, City, State, Zip Code			
BENEDICTINE LIVING COMMUNITY OF NEW LONDON			100 GLEN OAKS DRIVE NEW LONDON, MN 56273			

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4	) Item		(Y5)	Date	(Y4)	ltem		(Y5)	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	20560		03/01/2014		ID Prefix	20830		03/05/2014		ID Prefix	20910		03/05/2014
0	MN Rule 4658.	0405 Subp.	2		0	MN Rule 4658.0520	Subp.	1		Ŭ	MN Rule 4658	.0525 Subj	p. 5 A.I
LSC					LSC					LSC			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	21990		03/06/2014		ID Prefix	22000		03/06/2014		ID Prefix			
Reg. #	MN St. Statute	626.557 Sul	bd. 4		Reg. #	MN St. Statute 626.	.557 Su	bd.		Reg. #			
LSC					LSC					LSC			
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
			-					-					
Reg. # LSC			-		Reg. #					Reg. #			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			-		ID Prefix					ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			_
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg. #					Reg. #			
LSC			-		LSC					LSC			
			·										
Reviewed By	/	Reviewed E	Ву	D	ate:	Signature of	f Surve	yor:				Date:	
State Agency	/		BF/KJ		4/18/20	)14		20794				4	/3/2014
Reviewed By	/	Reviewed B	Ву	D	ate:	Signature of	f Surve	yor:				Date:	
CMS RO													
Followup to	Survey Comple	eted on:				Check f	or any	Uncorrected [	Deficie	encies. Was	a Summary of		
	2/5/2	014				Unco	orrecte	d Deficiencies	(CMS	-2567) Sent	to the Facility?	YES	NO
STATE FORM	I: REVISIT REP	ORT (5	5/99)			Page 1 of 1					Event ID:	TP0512	

#### **Post-Certification Revisit Report**

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

Í	Provider / Supplier / CLIA / Identification Number 245360	(Y2) Multiple Constr A. Building B. Wing		(Y3) Date of Revisit       IAIN BUILDING 01       4/10/2014					
Name of Facility				Street Address, City, State, Zip Code					
BENEDICTINE LIVING COMMUNITY OF NEW LONDON				100 GLEN OAKS DRIVE NEW LONDON, MN 56273					

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

(Y4) Item	(Y	5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
		Correction			Correction			Correction
ID Prefix		Completed 03/21/2014	ID Prefix		Completed	ID Prefix		Completed
Reg. #	NFPA 101	_			-	Reg. #		
0	K0056	_	LSC			U U		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #			Reg. #			Reg. #		
LSC		_	LSC			LSC		
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		_	ID Prefix			ID Prefix		
Reg. #		_	Reg. #			Reg. #		
LSC		_						
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		_						
Reg. # LSC		_	Reg. # LSC			Reg. #		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #						Reg. #		
LSC								
Reviewed By	Reviewed	іВу	Date:	Signature of Surve	yor:		Dat	e:
State Agency	/	PS/KJ	4/18/2014		27200	)		4/10/2014
Reviewed By	Reviewed	i By	Date:	Signature of Surve	yor:		Date	e:
CMS RO								
Followup to	Survey Completed on:			•		eficiencies. Was a		
	2/4/2014			Uncorrecte	u Denciencies	(CMS-2567) Sent to	o the Facility? YE	ES NO

DEPARTMENT OF HEALT	. –				CENTERS FOR M		: MEDICAI	D SERVICES
					AND TRANSMITTAL			TP05
	PART I -	TO BE COMPI	LETED BY T	THE STA	TE SURVEY AGENC	Y	Facil	lity ID: 00314
1. MEDICARE/MEDICAID PROVIDE	R NO.	3. NAME AND AI					E OF ACTION:	<u><b>2</b></u> (L8)
(L1) <b>245360</b> 2.STATE VENDOR OR MEDICAID N	IO.	(L4) 100 GLEN			UNITY OF NEW LOND	1. Initi		2. Recertification
(L2) <b>448348100</b>	NO.				(1.6) 5(3)			4. CHOW 6. Complaint
		(L5) NEW LO			(L6) <b>562</b>	15		9. Other
5. EFFECTIVE DATE CHANGE OF (	JWNEKSHIP	7. PROVIDER/SU	05 HHA	JOR Y 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full	Survey After Cor	mplaint
(L9) <b>02/01/2011</b> 6. DATE OF SURVEY <b>2/5/</b> 2	2014 (L34)	01 Hospital 02 SNF/NF/Dual	05 HHA 06 PRTF	09 ESKD 10 NF				
<ol> <li>DATE OF SURVEY 2/5/2</li> <li>ACCREDITATION STATUS:</li> </ol>	(L10)	03 SNF/NF/Distinct	07 X-Ray	10 I CF/III	14 CORF D 15 ASC	FISCAL Y	EAR ENDING I	DATE: (L35)
0 Unaccredited 1 TJC	(E10)	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE		12/31	
2 AOA 3 Other								
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia	nce With		And/Or Approved Waiver	s Of The Followir	ng Requirements	<u>:</u>
To (b):			equirements e Based On:		2. Technical Person		Scope of Service	
12. Total Facility Beds	<b>62</b> (L18)		cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rura		Medical Directo Patient Room Siz	
12.10.001100000	02 (110)				5. Life Safety Code		Beds/Room	
13.Total Certified Beds	<b>62</b> (L17)		npliance with Prog			(110)		
		Requirem	ents and/or Appli	ed Waivers:	* Code: <b>B</b> *	(L12)		
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1)	):	(L15)	
62								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	ARKS (IF APPLIC	ABLE SHOW LTC C	ANCELLATION	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGE	NCY APPROVA	L	Date:
Incoine Collmon	LIEE NIE H	3	3/28/2014			C .	0 11	04/06/2014
Jessica Sellner,	<u>NFE NE II</u>		/20/2014	(L19)	<u>Kate JohnsTon, Er</u>	nforcement	Specialist	(L20)
PAR	T II - TO BE (	COMPLETED E	BY HCFA RH	EGIONAI	L OFFICE OR SINGL	E STATE AG	ENCY	
19. DETERMINATION OF ELIGIBIL	ITY	20. COM	IPLIANCE WITH	H CIVIL	21. 1. Statement of	Financial Solvency	(HCFA-2572)	
<b>X</b> 1. Facility is Eligible to Pa	articipata	RIGI	HTS ACT:			ontrol Interest Disc		FA-1513)
2. Facility is not Eligible	articipate				5. Boui of the A			
2. Tuenky is not Englote	(L21)							
22. ORIGINAL DATE	23. LTC AGREE			<b>HENTE</b>		ION		<u></u>
			4. LTC AGREEN		26. TERMINATION ACT		(L30	
OF PARTICIPATION 11/01/1986	BEGINNINC	DATE	ENDING DA	TE	<u>VOLUNTARY</u> 01-Merger, Closure	00	INVOLUNTA 05-Fail to Meet	
	(T. 41)		(L. 0.5)		02-Dissatisfaction W/ Reim	bursement	06-Fail to Meet	2
(L24)	(L41)		(L25)		03-Risk of Involuntary Termi			rigicoment
25. LTC EXTENSION DATE:		IVE SANCTIONS n of Admissions:			04-Other Reason for Withdra		OTHER 07-Provider St	atus Change
	A. Suspension	n of Admissions.	(L44)				00-Active	atus chunge
(L27)	B. Rescind Su	uspension Date:	(211)					
			(L45)					
28. TERMINATION DATE:	20	). INTERMEDIARY	CARRIER NO		30. REMARKS			
20. TERMINATION DATE.	27		childlen no.		50. REAM INTE			
	(7. <b>a</b> - )	03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	I OF APPROVA	L DATE				
	52			-				
	(L32)			(L33)	DETERMINATION A	PPROVAL		

### C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

Page 2 Provider Number: 24- 5360 Item 16 Continuation for CMS-1539

At the time of the standard survey completed 2/5/14, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8224

February 21, 2014

Mr. James Laine, Administrator Benedictine Living Community Of New London 100 Glen Oaks Drive New London, Minnesota 56273

RE: Project Number S5360025

Dear Mr. Laine:

On February 5, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

# DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor Minnesota Department of Health 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 March 17, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 17, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

## PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

# PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

# VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

## Original deficiencies not corrected

Benedictine Living Community Of New London February 21, 2014 Page 4

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 May 5, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may 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 August 5, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

## **INFORMAL DISPUTE RESOLUTION**

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

Nursing Home Informal Dispute Process Minnesota Department of Health Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900 Benedictine Living Community Of New London February 21, 2014 Page 5

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145

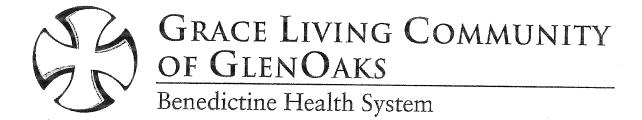
Telephone: (651) 201-7205 Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

ate Tomston

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File



Addendum to 2567 Plan of Correction

F225 Incidents will be reviewed at morning IDT meeting DON/ADON attend these meetings daily and by the RN Supervisors on the week-end. DON/ADON to review at Monday IDT meeting.

F226 In-services have been completed to Vulnerable Adult Policies and Procedures inclusive of resident to resident interactions. On-call staff are being in-serviced on-going and new hires at time of orientation by Social Service and DON. Ombudsman to in-service residents and staff in April regarding Resident Rights and Vulnerable Adult Regulations. See also plan of correction for F225.

F279 DON/ADON to monitor at time of admission, or with a change of status to the Dialysis. Completed on a monthly basis.

F323 R7 has been assessed and covered cup and specialized cover up has been ordered for R7 and it is now being utilized. All residents have been assessed and appropriate equipment is being used per assessments. Assessments will be completed at time of admit, reviewed quarterly, or with a change of condition.

F323 R45 Care Plan and NAR assignment sheets accurately reflect toileting schedules and staff are monitored to adhere to current care plans and assignment sheets. This is to prevent further falls. In-serviced on 3/5/2014 in-service. NA/R assignment/ toileting sheets will be audited by RN Managers to ensure care plan being followed to prevent further falls. DON/ADON to monitor for audit completion monthly. In-servicing completed to Incident/accident reporting inclusive of falls and following interventions. New form identifies and assesses fall incidents for proper and timely interventions. In-serviced 3/5/2014

Capuil a anderson PN DON 3/14/14

### RECEIVED

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F 000INTIAL COMMENTSThe facility's plan of correction (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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.F 225483.13c(r)(1)(ii)-(iii), c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALSThe facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.F 225	PREFIX	(FACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR	3E	(X5) COMPLETION DATE
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SS=DINVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALSThe facility ensures that all allegations of abu are investigated and reported in a timely manner.The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.The facility ensures that all allegations of abu are investigated and reported in a timely manner.a. DON interviewed R22 on 2/2/14 and R22 immediately refuted these allegations. She stated "I have not been sexually abused, and don't know where he gets those ideas." Most recent BIMS score for R22 is 15 indicating cognitively intact. DON interviewed the male	F 225	as your allegation of Department's accept bottom of the first pa be used as verifcatio Upon receipt of an a revisit of your facility validate that substan regulations has been your verification.	compliance upon the ance. Your signature at the ge of the CMS-2567 form will n of compliance. cceptable POC an on-site may be conducted to tial compliance with the n attained in accordance with	F	225			
The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	SS=D	INVESTIGATE/REPG ALLEGATIONS/IND The facility must not been found guilty of mistreating residents had a finding enterer registry concerning a of residents or misal and report any know court of law against indicate unfitness fo other facility staff to or licensing authoriti The facility must ensi- involving mistreatme including injuries of misappropriation of immediately to the a to other officials in a through established State survey and ce The facility must ha	ORT IVIDUALS employ individuals who have abusing, neglecting, or s by a court of law; or have d into the State nurse aide abuse, neglect, mistreatment opropriation of their property; /ledge it has of actions by a an employee, which would r service as a nurse aide or the State nurse aide registry ies. sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law procedures (including to the prtification agency). ve evidence that all alleged		H Jun J	<ul> <li>are investigated and reported i manner.</li> <li>a. DON interviewed R22 on 2/2 immediately refuted these alle stated "I have not been sexuall don't know where he gets those recent BIMS score for R22 is 15 cognitively intact. DON intervie orderly identified 2/2/2014 and directed that no male staff go i give care.</li> <li>R 18 Care Plan Problem: "Know truth" Approach: Allow to vent events and complaints to make clear." Most recent BIMS score</li> </ul>	n a time 2/14 and gations. y abuse ie ideas. indicat ewed the d immed the the the the the the the the the the the the the the the	ely I R22 She d, and I " Most ing e male diately t room to retch the rify outh is
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE ADD 3/1/17			$\gamma \gamma $			ADON	3	1-7/14

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

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

Event ID: TP0511

Facility ID: 00314

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If continuation sheet Page 1 of 29

STATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	). 0938-039 SURVEY LETED	
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F 225	prevent further potent investigation is in pro- The results of all inve- to the administrator of representative and to with State law (includ certification agency) wincident, and if the all- appropriate corrective This REQUIREMENT by: Based on interview a facility failed to ensure immediately reported were thoroughly investigation and R35) allegations of Findings include: R18 made an allegation abused by a staff mer report the allegation to investigate this allegation allegation to investigate this allegation and R35 quarterly Minim 12/11/13, included mod impairment, had no de problems.	hly investigated, and must tial abuse while the gress. stigations must be reported r his designated other officials in accordance ing to the State survey and vithin 5 working days of the eged violation is verified a action must be taken. is not met as evidenced ind document review, the e allegations of abuse were to the state agency (SA), stigated, and failed to for resident protection n for 2 of 6 resident (R18 of abuse, and neglect. on that R22 had been inber. The facility failed to be the state agency, and tion of abuse. um Data Set (MDS) dated iderate cognitive elusions or behavior	F 2	l i i i i i i i i i i i i i i i i i i i	indicating moderately cognitive Review of interdisciplinary prog reveals numerous occasions of I concerns that were determined voicing concerns related specific residents. Following investigatic concern in the past, R18 stated stretched the truth a little." Inter Licensed staff and NAR'S, Physic Occupational Therapy who work couple often completed 2/2 thro Resident had not voiced this con their knowledge prior to voicing on 2/2/14. ncident with R5 and R35 was inventer present to talk about this incident cordial to each other. R35 has mod lifferent table in the Dining Room wo residents continue to engage each other.	ress not R18 voic to be fa cally to n on relate to SW, " rviews v al Thera with 2/6 cern to s it to surv restigate with sta t, and ar oved to a n, but th socially re been I state of willfu	es ing Ise and nale d to a Maybe I vith py and is staff to veyor d aff re ese with been I	
· vonere un vone	When interviewed on stated, "He sexually a R18 went onto explair		in	itent for resident to resident alte etermination re: whether the inc	rcations			

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

Facility ID: 00314

If continuation sheet Page 2 of 29

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/21/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245360	B, WING	۰.	02/05/2014
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F 225	about a week ago. "I nothing but a uh uh b reported this to a, "He was unsure who the r	ning R22 inappropriately He's a filthy beast, he is east." R18 stated he had ead nurse," last week, but nurse was and nothing had ey didn't understand me, and	F 225		
	was cognitively intact 2/2/14, at 2:15 p.m. R "sexually assaulted" a jealous." She verified	dated 1/8/14, included she . When interviewed on 22 stated she had not been and R18, "Has always been I staff had not asked her legation made by R18.			
	assistant director of n was not aware of any	2/2/14, at 2:50 p.m. the ursing (ADON) stated she allegation made by R18 ation was reported by the I at this time.		· ·	
	unaware R18 had ma	se (LPN)-A stated she was de allegations of abuse of aware of any restrictions of			
	R18 had made allegat	-A stated she was unaware tions of abuse of R22. y has four male nursing ever heard of any one			

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

Facility ID: 00314

If continuation sheet Page 3 of 29

PRINTED: 02/21/2014 FORM APPROVED

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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<ul> <li>F 225 Continued From page 3 When Interviewed on 2/4/14, at 11:30 p.m. the director of nursing (DON) and social services ((SS)-A denied any knowledge of the allegations of abuse of R22 made by R18. Even through this had been reported to the ADON on 2/2/14. They both verified an investigation of the allegation had not been initiated, or reported to the state agency (SA).</li> <li>When interviewed on 2/5/14, at 11:30 a.m. the DON stated she had not taken the allegation of abuse of R22 made by R18 seriously because R18 has, "Maren depreciption." Three were no measures taken to protect R22 as no investigation had been stated. The DON would report it to the SA and start an investigation now, three days after the allegation was reported to the ADON.</li> <li>When interviewed on 2/5/14, at 11:00 a.m. the administrator stated there was, "Some taik," about the allegations made by R18 last week, but they had asked R22 and she denied it. There was no investigation documented, and a report to the SA had not been completed.</li> <li>Review of R18's progress notes from 10/1/13 through 2/4/14 di not identify any, "alkered perception," delusions or inappropriate behavior. Also, here was no indication in the record that an investigation aboes tarted by the facility regarding R18 allegation of abuse to R22.</li> <li>Even though R18 had made allegations of abuse by a "male care giver" towards R22, "about a</li> </ul>	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
by a "male care giver" towards R22, "about a	F 225	<ul> <li>When interviewed on director of nursing (D (SS)-A denied any kr abuse of R22 made I had been reported to both verified an invest not been initiated, or (SA).</li> <li>When interviewed or DON stated she had abuse of R22 made R18 has, "Altered per measures taken to p investigation had been report it to the SA and three days after the ADON.</li> <li>When interviewed on administrator stated about the allegations they had asked R22 was no investigation the SA had not been</li> <li>Review of R18's prot through 2/4/14 did n perception," delusio Also, there was no i investigation had be</li> </ul>	<ul> <li>2/4/14, at 1:03 p.m. the DON) and social services howledge of the allegations of by R18. Even though this the ADON on 2/2/14. They stigation of the allegation had reported to the state agency</li> <li>2/5/14, at 11:30 a.m. the not taken the allegation of by R18 seriously because reception." There were no rotect R22 as no en started. The DON would d start an investigation now, allegation was reported to the</li> <li>2/5/14, at 11:00 a.m. the there was, "Some talk," is made by R18 last week, but and she denied it. There documented, and a report to nompleted.</li> <li>gress notes from 10/1/13 ot identify any, "altered ns or inappropriate behavior. Indication in the record that an the started by the facility</li> </ul>	F	225	have been held for staff and capture on-call staff, regardi New staff will be orientated and procedures at time of hi d. Incident reports will be au completion weekly with resu Quality Assurance Committee	will be on- ng these u to these p re. Idited for ults reporte	-going to updates. olicies ed to
		Even though R18 habits by a "male care give	er" towards R22, "about a	unerajonari kanakora ja minakano			continuation of	heet Page A of f

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 02/21/2014 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245360	B. WING		02/05/2014
	Rovider or supplier	TY OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP CC 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	DDE
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETIC
F 225	week ago. " The alleg the facility on 2/2/14, report the allegation allegation to investiga	e 4 gation was again reported to but the facility failed to to the SA, did not act on the ate the alleged abuse of R22, otected R22 during their	F 2	25	
	R5 had intentionally backed her wheel chair into R35, while R35 was walking in a walker behind R5. The facility did not report the resident to resident abuse to the SA, nor had they investigation the allegation of resident to resident abuse. R5's quarterly MDS dated 1/31/14, included moderate cognitive impairment and utilized a wheel chair for mobility.	walking in a walker behind ot report the resident to a SA, nor had they gation of resident to resident dated 1/31/14, included mpairment and utilized a			
	R5's progress note d "Resident [R35] was room] for lunch and l [wheel chair] and [R4 and tired of people b resident [R35] sidew resident just as she When interviewed or stated she had withe her wheel chair into not actually fallen or shaken and upset th attempt to knock her	lated 1/29/14, indicated, ambulating into DR [dining her walker bumped [R5's] w/c 5] was saying, 'I'm so sick bumping me', kept pushing ays and writer caught was about to tip over." In 2/5/13, at 9:09 a.m. LPN-B essed R5, "Intentionally," back R35, on 1/29/14. R35 had been injured, but was visibly at her table mate would rover. LPN-B stated she did			
	not think this was a not reported it.	reportable incident and had 6 dated 1/24/14, included			

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

PRINTED: 02/21/2014 FORM APPROVED

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION	(X3) DAT	O. 0938-03 E SURVEY PLETED
NAME OF F	PROVIDER OR SUPPLIER	245360	B. WING			/05/2014
				REET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON	1	GLEN OAKS DRIVE		
				W LONDON, MN 56273		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 225	Continued From page	5	F 225			
	intact cognition and ut ambulation.		1 225			
	When interviewed on	2/5/13, at 5:05 p.m. RN-B				
	stated she had review and R35. Since R35 I	ed the incident, between R5				
	injuries, this was not a	reportable event to the SA,				
	nor had they complete investigation of the inc however reported the	d any incident report or ident. RN-B stated she incident to SS-A.			ar an	
	stated she was aware wheelchair into R35, b	ut had not reported it or				
	investigated further be sustained any injuries. each other."	cause no one had "They were nit-picking with				
	harm R5, therefore the investigated or reported stated they should have	feel R35 really wanted to incident had not been d to the SA. The DON e reported it to the SA and				
	investigated the incider resident to resident abu	nt further to determine if use had occurred.				
	Adult Policies Compone	nmediate investigation, nt, and immediate				
a c	an interview of the perso occur, and staff would b	stigation Policy, included on reporting abuse would e interviewed. Accused rred from further contact an investigation				,
	183.13(c) DEVELOP/IM		F 226			

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

Facility ID: 00314

If continuation sheet Page 6 of 29

CENTERS FOR MEDICARE & MEDICATO SETUTION         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION       (X3) DATE S COMPL	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION       (X3) DATE S COMPL         245360       B. WING       02/0         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       00 ELEN GAKS DRIVE         BENEDICTINE LIVING COMIMUNITY OF NEW LONDON       NEW LONDON, MIN 56273       02/0         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL TAG       D       PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (CACH DEFICIENCY MUST BE PRECIDED BY FULL TAG       D       PROVIDER'S PLAN OF CORRECTION SHOULD BE (CACH CORRECTIVE ACTION SHOULD SHOULD BE (CACH CORRECTIVE ACTION SHOULD BE (CACH CORRECTIVE ACTION SHOULD BE (CACH CORRECTIVE ACTION SHOULD SHOULD BE (CACH CORRECTIVE ACTION SHO	0938-0391
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         BENEDICTINE LIVING COMMUNITY OF NEW LONDON       SUMMARY STATEMENT OF DEFICIENCIES       NEW LONDON, MIN 56273         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S FLAN OF CORRECTION         (K4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S FLAN OF CORRECTION         (K4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S FLAN OF CORRECTION         (K4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S FLAN OF CORRECTION         (K4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S FLAN OF CORRECTION         (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)       TAG       PROVIDER'S FLAN OF CORRECTION         (K4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S FLAN OF CORRECTION         (EACH DEFICIENCY)       TAG       PROVIDER'S FLAN OF CORRECTION       (EACH DEFICIENCY)         F 226       Continued From page 6       a., b., c. The facility has updated policies       procedures to hybrid state and Federal         SS=D       ABUSE/NEGLECT, ETC POLICIES       F 226       a., b., c. The facility has updated policies         In the facility must develop and implement written       policies and procedures that prohibit       number of hire.	
MAME OF PROVIDER OR SUPPLIER       100 GLEN OAKS DRIVE         BENEDICTINE LIVING COMMUNITY OF NEW LONDON       100 GLEN OAKS DRIVE         (X4) ID PREFIX       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX       PROVIDER'S PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 226       Continued From page 6 ABUSE/NEGLECT, ETC POLICIES       F 226       a., b., c. The facility has updated policiess procedures to hybrid state and Federal guidelines on resident to resident alterco and for accident/ incident reporting.         Vulnerable Adult reporting on these guid have been in-serviced to staff and it is o to capture on-call staff. New hires will b orientated to these policies and procedure by: Based on document review and interview, the facility failed to follow their abuse prohibition policy to ensure all allegations of abuse were immediately reported to the state agency (SA) and throcupubly investigated for 2 of 6 residents	5/2014
BENEDICTINE LIVING COMMUNITY OF NEW LONDON       100 GLEN OAKS DRIVE         0x41 ID       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       ID       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 226       Continued From page 6 ABUSE/NEGLECT, ETC POLICIES       F 226       a., b., c. The facility has updated policies procedures to hybrid state and Federal guidelines on resident to resident alterc and for accident/ incident reporting.         Vulnerable Adult reporting on these guid have been in-serviced to staff and it is o to capture on-call staff. New hires will k orientated to these policies and procedure by: Based on document review and interview, the facility failed to follow their abuse prohibition policy to ensure all allegations of abuse were immediately reported to the state agency (SA) and throughly investigated for 2 of 6 residents       d. Quality Assurance Committee will rev reports and procedures being followed	
(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 DEFICIENCY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 226       Continued From page 6 ABUSE/NEGLECT, ETC POLICIES       a., b., c. The facility has updated policies procedures to hybrid state and Federal guidelines on resident to resident alterc and for accident/ incident reporting.         Vulnerable Adult reporting on these guid have been in-serviced to staff and it is o to capture on-call staff. New hires will k orientated to these policies and procedure by: Based on document review and interview, the facility failed to follow their abuse prohibition policy to ensure all allegations of abuse were immediately reported to the state agency (SA) and thoroughly investigated for 2 of 6 residents       d. Quality Assurance Committee will rev reports and procedures being followed	
(A) ID       SUMMARY STATEMENT OF DELOCIDED BY FULL       PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL         REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX       TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 226       Continued From page 6       a., b., c. The facility has updated policies         SS=D       ABUSE/NEGLECT, ETC POLICIES       F 226       a., b., c. The facility has updated policies         The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.       F 226       a., b., c. The facility reporting on these guidelines on resident to resident altercr and for accident/ incident reporting.         Vulnerable Adult reporting on these guidelines on document review and interview, the facility failed to follow their abuse prohibition policy to ensure all allegations of abuse were immediately reported to the state agency (SA) and thoroughly investigated for 2 of 6 residents       d. Quality Assurance Committee will review reports and procedures being followed	
SS=DABUSE/NEGLECT, ETC POLICIESprocedures to hybrid state and Federal guidelines on resident to resident alterc and for accident/ incident reporting. Vulnerable Adult reporting on these guid have been in-serviced to staff and it is o to capture on-call staff. New hires will b orientated to these policies and procedure by: Based on document review and interview, the facility failed to follow their abuse prohibition policy to ensure all allegations of abuse were immediately reported to the state agency (SA) and thoroughly investigated for 2 of 6 residentsprocedures to hybrid state and Federal guidelines on resident to resident alterc and for accident/ incident reporting. Vulnerable Adult reporting on these guid have been in-serviced to staff and it is o to capture on-call staff. New hires will b orientated to these policies and procedure time of hire.d. Quality Assurance Committee will rev reports and procedures being followed and thoroughly investigated for 2 of 6 residents	(X5) COMPLETION DATE
Administrator Responsible identify resident to resident abuse, or injures of unknown source. Administrator Responsible e. Correction Date 3/6/2014	ations delines n-going pe ures at view at
Findings include: An undated policy entitled GlenOaks Care Center Vulnerable Adult Policies Components of the Abuse Program, included investigation and immediate reporting of allegations of abuse. The policy identified verbal, sexual, physical, and mental abuse, as well as, neglect, misappropriation of resident property, and involuntary seclusions. The policy also included protection of the alleged victim during an investigation. However, the policy failed to include resident to resident abuse or injuries of unknown source.	
An undated Abuse Investigation Policy also failed       Include resident to resident abuse or injuries of         FORM CMS-2567(02-99) Previous Versions Obsolete       Event ID: TP0511       Facility ID: 00314       If continuation sheet	eet Page 7 of :

DEPARTI						FOR	D: 02/21/2014 M APPROVED 0. 0938-0391
STATEMENT O	F DEFICIENCIES CORRECTION	/EDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		E SURVEY PLETED
		245360	B. WING			02	2/05/2014
	ROVIDER OR SUPPLIER	Y OF NEW LONDON		100 0	ET ADDRESS, CITY, STATE, ZIP CODE GLEN OAKS DRIVE / LONDON, MN 56273		
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	Continued From page unknown source.	97	F	226			
	DON verified the faci resident to resident a abuse, unless there	n 2/5/14, at 5:27 p.m. the lity's policy did not identify ltercations as potential was an injury. The facility nd a definition of injuries of part of their facility policy.			•		
	abused by a staff me	tion that R22 had been ember. The facility failed to to the state agency, and ation of abuse as identified					
	12/11/13, included n impairment, had no problems.	delusions or behavior					
	stated, "He sexually R18 went onto expl giver," had been too about a week ago. nothing but a uh uh reported this to a, "	n 2/2/14, at 2:03 p.m. R18 assaulted my wife [R22]." ain an unknown, "Male care uching R22 inappropriately "He's a filthy beast, he is beast." R18 stated he had Head nurse," last week, but e nurse was and nothing had hey didn't understand me, and pusly."			• •		
	was cognitively inta 2/2/14, at 2:15 p.m "Sexually assaulted isolous ". She verif	S dated 1/8/14, included she act. When interviewed on . R22 stated she had not been, d," and R18, "Has always been ied staff had not asked her allegation made by R18.					n sheet Page 8 c

PRINTED: 02/21/2014 FORM APPROVED OMB NO: 0938-0391

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT O	S FOR MEDICARE & of deficiencies correction	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	(X3) DATE SU COMPLET	
		245360	B. WING			02/05	/2014
	ROVIDER OR SUPPLIER	Y OF NEW LONDON		100	EET ADDRESS, CITY, STATE, ZIP CODE GLEN OAKS DRIVE N LONDON, MN 56273		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE (	(X5) COMPLETION DATE
F 226	When interviewed or	1 2/2/14, at 2:50 p.m. the	F	226			
	was not aware of an	nursing (ADON) stated she y allegation made by R18 gation was reported by the N at this time.					
	When interviewed on 2/4/14, at 12:44 p.m. licensed practical nurse (LPN)-A stated she was unaware R18 had made allegations of abuse of R22. LPN-A was not aware of any restrictions of male nursing assistants caring for R22.						
	When interviewed on 2/4/14, at 12:54 p.m. registered nurse (RN)-A stated she was unaware R18 had made allegations of abuse of R22. RN-A stated the facility has four male nursing assistants, and had never heard of any one complaining about any of them.						
	director of nursing ( (SS)-A denied any b abuse of R22 made had been reported both verified an inve	n 2/4/14, at 1:03 p.m. the DON) and social services knowledge of the allegations of by R18. Even though this to the ADON on 2/2/14. They estigation of the allegation had or reported to the state agency					
	DON stated she ha abuse of R22 made R18 has, "Altered p measures taken to	on 2/5/14, at 11:30 a.m. the d not taken the allegation of by R18 seriously because perception." There were no protect R22 as no een started. The DON would			sility ID: 00314	continuation shee	t Dare 0

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

PRINTED: 02/21/2014 FORM APPROVED OMB NO. 0938-0391

CENTER	KS FOR MEDICARE &	MEDICAID SERVICES		ny na na na fan yn fel an ar an ar	OMI	<u>3 NO. 0938-039</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		DATE SURVEY
		245360	B. WING			02/05/2014
NAME OF P	ROVIDER OR SUPPLIER		ารสารมาร์การสารมากสารสารสาร	STREET ADDRESS, CITY, STAT	E, ZIP CODE	
BENEDIC	TINE LIVING COMMUNIT	TY OF NEW LONDON		100 GLEN OAKS DRIVE NEW LONDON, MN 56273		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI CROSS-REFERENCI	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 226		e 9 d start an investigation now, llegation was reported to the	F			
	administrator stated to about the allegations they had asked R22 a	2/5/14, at 11:00 a.m. the here was, "Some talk," made by R18 last week, but and she denied it. There documented, and a report to completed.				
	through 2/4/14 did no perception," delusions Also, there was no inc	s or inappropriate behavior. dication in the record that an n started by the facility				
	by a "male care giver" week ago. " The alleg the facility on 2/2/14, I report the allegation to allegation to investiga nor had the facility pro-	I made allegations of abuse ' towards R22, "about a ation was again reported to out the facility failed to o the SA, did not act on the te the alleged abuse of R22, otected R22 during their ed by their abuse policies.			•••	
	R35, while R35 was w R5. The facility did not resident abuse to the			· · · · · · · · · · · · · · · · · · ·		
	R5's quarterly MDS da moderate cognitive im	ated 1/31/14, included pairment and utilized a				
M CMS-2567	(02-99) Previous Versions Obso	lete Event ID: TP051	1	Facility ID: 00314	If continuation a	heet Page 10 of 2

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

Event ID: TP0511

Facility ID: 00314

If continuation sheet Page 10 of 29

### DEPARTMENT OF HEALTH AND HUMAN SERVICES THE FOR MEDICARE & MEDICARD SERVICES

PRINTED: 02/21/2014 FORM APPROVED OMB NO. 0938-0391

CENIER	S FOR MEDICARE &	NEDICAID SERVICES	wysię obiaccał word occimental			T.	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
-		245360	B, WING			02/	05/2014
NAME OF PE	ROVIDER OR SUPPLIER		AADTTACK COULD IN LOUGH AND	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	1 ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) (			10	00 GLEN OAKS DRIVE		
BENEDIC	TINE LIVING COMMUNIT	Y OF NEAR FONDON		N	EW LONDON, MN 56273		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 226	"Resident [R35] was room] for lunch and h [wheel chair] and [R5 and tired of people b resident [R35] sidewa resident just as she w When interviewed or stated she had witne her wheel chair into h not actually fallen or shaken and upset the attempt to knock her not think this was a r not reported it. R35's quarterly MDS intact cognition and ambulation. When interviewed or stated she had revie and R35. Since R35 injuries, this was not nor had they comple investigation of the ii however reported th When interviewed of stated she was awa wheelchair into R35 investigated further	ity. ated 1/29/14, indicated, ambulating into DR [dining her walker bumped [R5's] w/c 6] was saying, 'I'm so sick umping me', kept pushing ays and writer caught was about to tip over." a 2/5/13, at 9:09 a.m. LPN-B ssed R5, "Intentionally," back R35, on 1/29/14. R35 had been injured, but was visibly at her table mate would over. LPN-B stated she did eportable incident and had c dated 1/24/14, included utilized a walker for a 2/5/13, at 5:05 p.m. RN-B wed the incident, between R5 b had not sustained any c a reportable event to the SA, ated any incident report or ncident. RN-B stated she	F	226			
	When interviewed o	n 2/5/14, at 5:27 p.m. the				an line an David of Martin and	A CONTRACTOR OF CONTRACTOR
	whom intorviewed e			nt mean fully	lí esti	auction sho	at Page 11 of 20

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

Event ID: TP0511

Facility ID: 00314

If continuation sheet Page 11 of 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES	

PRINTED: 02/21/2014 FORM APPROVED OMB NO 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NC	). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COMP	SURVEY LETED
		245360	B. WING		02/	05/2014
	ROVIDER OR SUPPLIER	Y OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP COE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273		er of de de vier fan fan de
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 226 F 279	harm R5, therefore the investigated or report stated they should ha investigated the incid resident to resident a 483.20(d), 483.20(k)(	t feel R35 really wanted to le incident had not been ed to the SA. The DON we reported it to the SA and ent further to determine if buse had occurred. 1) DEVELOP	F 2: F 2	The care plans describe be furnished to attain or highest practicable phys	r maintain the r ical, mental and	esident's
SS=D	to develop, review an comprehensive plan The facility must deve plan for each residen objectives and timeta medical, nursing, and	e results of the assessment d revise the resident's		<ul> <li>a. R60 's care plan was used as the reflect current services to jugular/chest area} for D</li> <li>b. Care plans for other redialysis were reviewed a services being provided.</li> </ul>	updated on 2/7/ to the right IJ [ir Dialysis. residents receivi and are reflectiv	nternal
	The care plan must d to be furnished to atta highest practicable pl psychosocial well-bei §483.25; and any ser be required under §4 due to the resident's of			c. A short-term care play line was created for new or residents with new o used prior to completio Significant Change in Sta RN Manager responsible admission/ initiation of	vly admitted res nset of dialysis n of Admission/ atus MDS assess e for implemen	sidents to be v sments.
	by: Based on observatio review, the facility fail (R60) who received d	is not met as evidenced n, interview, and document ed to ensure 1 of 1 residents ialysis at an outside unit, loped to instruct staff on how s resident.		d. DON/ADON to Audit plans for accuracy for a admitted/ new initiation reported to the Quality e. Corrected 3/1/2014	ll residents new n of dialysis wit	dy h results

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

Facility ID: 00314

If continuation sheet Page 12 of 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES 

PRINTED: 02/21/2014 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE & I	MEDICAID SERVICES			na sana na manana ana amin'ny fanina amin'ny fanina dia amin'ny fanasana amin'ny fanana amin'ny fanina amin'ny	-	
and the second se	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		245360	B, WING			02/	05/2014
NAME OF PE	ROVIDER OR SUPPLIER		ne anna fa tha ann an ann ann ann ann ann ann ann an	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	00 GLEN OAKS DRIVE		
BENEDIC	TINE LIVING COMMUNIT	A OL WEAR FOUDOW	the set of the second	N	JEW LONDON, MN 56273		0//0
(X4) ID PREFIX , TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ЧX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 279	Continued From page	e 12	F	279			
	Findings include:						
	11/4/13, identified mo	imum data set (MDS) dated oderate cognitive impairment ve assistance with all ng (ADL's) except eating.					
	resident received dia Monday, Wednesda identified on the care (interjugular/ in the c for dialysis. The car regarding the care o "monitor the access pain, and swelling; I give injections, or dr access in; no tight c should be worn on a shunt every shift for Notify doctor of pos as: pain in extremit unable to feel the bu interventions identifi	ed 2/3/14, identified the alysis at an outside facility on y, and Fridays. R60 was e plan as having a right IJ chest area) tunneled catheter re plan instructed staff of the dialysis access site to, site for redness, bleeding Do not take blood pressure, raw blood from arm with lothing, jewelry, or dressing arm with access; monitor presence of bruit and thrill; sible occlusion of shunt such y, fingers cool to touch and ruit through the shunt." The ied in the care plan were for a ialysis through an arm istula or shunt and not an IJ, the chest.					A
	stated she received on Monday, Wedne right LI catheter site	2/5/14 at 10:00 a.m. R60 d dialysis at an outside facility esday, and Fridays through a e in her chest. The resident unit does all the care of the		-111-2750-74	Tealling 10214	ontinuation st	eet Page 13 of 2

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Event ID: TP0511

Facility ID: 00314

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			PRINTED: (	02/21/2014 PPROVED
CENTER	RS FOR MEDICARE &	MEDICAID'SERVICES			OMB NO. 0	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · · ·	E CONSTRUCTION	(X3) DATE SUI COMPLET	RVEY
		.245360	B. WING		02/05/	2014
NAME OF F	PROVIDER OR SUPPLIER	lannoozennen zenen arezen arezen arezen en eren eren eren zen arezen ezen eren eren eren eren eren eren		STREET ADDRESS, CITY, STATE, ZIP CODE	011001	
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		00 GLEN OAKS DRIVE IEW LONDON, MN 56273		
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F 279	Continued From page	13	F 279			
	access site, the facilit anything.	/ does not have to do				
	was observed on her	n. R60's right IJ catheter upper right chest area.  The ered with a clear bandage.			NO. 1	
	practical nurse (LPN)- catheter for dialysis ar ensure the catheter di on. LPN-A verified the not correct, and the in R60's care plan was fo	5/14, at 10:30 a.m. licensed A stated R60 had a right IJ ad the facility needed to d not get wet or get pulled e residents care plan was formation contained on or someone receiving n access, such as a fistula				
	director of nursing (AD plan did not instruct st	5/14, at 7:05 p.m. assistant ON) verified R60's care aff on how to care for the e and it was for a dialysis ialysis using an arm				
		o for infection, avoiding or manipulation of the ess pulls out to apply 20 minutes.	F 315	· · ·		

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Event ID: TP0511 Facility ID: 00314

If continuation sheet Page 14 of 29

(KA) ID PREFIX TAG       Description and pericency must be preceded by FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH DOMAGE INF ALL ION ANOUNCE INFORMATION)       Description         F 315       Continued From page 14 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.       F 315       Based on a resident's comprehensive assessment the facility will ensure that our residents who have a catheter will have med justification for the indwelling catheter.         This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R13) reviewed with an indwelling urinary catheter had medical justification for continued use, or attempt to discontinue the indwelling catheter.       c. Continued need for hospice initiated device and medications will be reviewed with the Significant Change in Status MDS following hospice discontinuation for every resident the	DEPART	MENT OF HEALTH A	AND HUMAN SERVICES					MAPPROVED ). 0938-0391
243360       Image: STREET ADDRESS, CITY, STATE, ZIP CODE         BENEDICTINE LIVING COMMUNITY OF NEW LONDON       STREET ADDRESS, CITY, STATE, ZIP CODE         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES         PREFIX       SUMMARY STATEMENT OF DEFICIENCIES         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)         F 315       Continued From page 14         Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident scincal condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.       F 315       Based on a residents with indwelling catheter.         This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility suffication for continued use, or attempt to discontinue the indwelling catheter.       c. Continued need for hospice initiated devid and medical ions will be reviewed with the Significant Change in Status MDS following hospice discontinuation for every resident tit	STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					
NAME OF PROVIDER OK SUPPLIER     100 GLEN OAKS DRIVE       BENEDICTINE LIVING COMMUNITY OF NEW LONDON     NEW LONDON, MN 56273       (X4) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE OROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     COME       F 315     Continued From page 14 Based on the resident's comprehensive assessment, the facility without an indwelling catheter is not catheterized unless the resident's clincal condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent uniary tract infections and to restore as much normal bladder function as possible.     F 315     Based on a resident's with indwelling catheter.       This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R13) reviewed with an indwelling urinary catheter had medical justification for continued use, or attempt to discontinue the indwelling catheter.     C. Continued need for hospice initiated device and medications will be reviewed with the Significant Change in Status MDS following hospice discontinuation for every resident tilt			245360	B. WING			02/	05/2014
C(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCY NUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAGTEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)F 315Continued From page 14F 315Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.F 315Based on a resident's comprehensive assessment the facility will ensure that our residents clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.F 315B ased on a resident's comprehensive assessment the facility will ensure that our residents with indwelling catheter. a. Catheter has been removed.This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R13) reviewed with an indwelling urinary catheter had medical justification for continued use, or attempt to discontinue the indwelling catheter.C. Continued need for hospice initiated device and medications will be reviewed with the Significant Change in Status MDS following hospice discontinuation for every resident th			ITY OF NEW LONDON		10	0 GLEN OAKS DRIVE EW LONDON, MN 56273	TION	(15)
<ul> <li>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</li> <li>This REQUIREMENT is not met as evidenced by:</li> <li>Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R13) reviewed with an indwelling urinary catheter had medical justification for continued use, or attempt to discontinue the indwelling catheter.</li> </ul>	PREFIX		NCY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETION DATE
Findings include:discontinues hospice services.R13 quarterly Minimum data set (MDS) dated 12/20/14, identified the resident had severe cognitive impairment, required extensive assistance with all activities of daily living (ADL's), and had an indwelling urinary catheter.d. Audits will be completed monthly for all residents discontinuing hospice services wit results reported to the Quality Assurance Committee.During observation on 2/3/14 at 10:40 a.m. R13 was observed laying in bed with a urinary catheter bag hanging from the bottom of the bedframe.e. DON or Designee responsible for monitor Correction date March 5, 2014.R13's Progress Notes dated 1/24/14, indicated a fax was sent to the residents physician, "relatedrelated	F 315	Based on the resid assessment, the fa resident who enters indwelling catheter resident's clinical c catheterization was who is incontinent treatment and serve infections and to re- function as possibl This REQUIREME by: Based on observe review, the facility (R13) reviewed wi had medical justifi- attempt to disconti Findings include: R13 quarterly Min 12/20/14, identifie cognitive impairm assistance with al and had an indwe During observation was observed lay bag hanging from	ent's comprehensive cility must ensure that a is the facility without an is not catheterized unless the condition demonstrates that is necessary; and a resident of bladder receives appropriate rices to prevent urinary tract estore as much normal bladder le. ENT is not met as evidenced ation, interview, and document failed to ensure 1 of 3 residents th an indwelling urinary catheter cation for continued use, or inue the indwelling catheter. imum data set (MDS) dated d the resident had severe ent, required extensive I activities of daily living (ADL's), elling urinary catheter. on on 2/3/14 at 10:40 a.m. R13 ing in bed with a urinary catheter atheter in the bottom of the bedframe.	F	315	assessment the facility will e residents who have a cathet justification for the indwellin a. Catheter has been remove b. All other residents with in have been reviewed for app continued use of catheter. c. Continued need for hospi and medications will be rev Significant Change in Status hospice discontinuation for discontinues hospice service d. Audits will be completed residents discontinuing hos results reported to the Qua Committee. e. DON or Designee respon	ensure that er will hav ng catheter ed. ndwelling c propriatene iewed with MDS follo every resid es. monthly for spice servic ality Assura	e medical r. atheters ess of d devices a the wing dent that or all es with ince

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Facility ID: 00314

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PRINTED: 02/21/2014

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 02/05/2014 245360 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 100 GLEN OAKS DRIVE BENEDICTINE LIVING COMMUNITY OF NEW LONDON NEW LONDON, MN 56273 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 315 F 315 Continued From page 15 hospice for comfort reasons as we thought her life expectancy was short along with her diagnoses of bladder prolapsed, atrophic vaginitis , urine retention with high PVR's [post void residual], abdominal distension, pain, and little to no voiding. However, now that she is off hospice related to stabilized condition will need documenting to continue to support her catheter use or would a trial of [discontinue] Foley [brand name urinary catheter] be appropriate. She does not regularly use the toilet and would likely be incontinent so to check PVR's would be inaccurate related to uncertainty of when she voided. Ask [physician] if to continue Foley use please list diagnoses reason and how often should we change Foley." R13's progress note dated 1/25/14, indicated the facility had received a faxed response from the physician, "Diagnoses for continued [Foley] catheter use is vaginitis with skin breakdown and to change Foley every 1 month." R13's Elimination/ Incontinence/ Indwelling Catheter Assessment dated 1/15/14, indicated R13 had dribbling and very slow interrupted stream and had a urinary catheter. The summary of the report included, "Resident has been in the past frequently incontinent of void... Resident had a [urinary] catheter placed on 9/19/13 per hospice standing orders due to high PVR's, abdominal distension, pain, and little to no voiding ... " Review of progress notes for R13 prior to initiation of the indwelling urinary catheter included the following: If continuation sheet Page 16 of 29 Facility ID: 00314 Event ID: TP0511 FORM CMS-2567(02-99) Previous Versions Obsolete

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		D HUMAN SERVICES MEDICAID SERVICES				FOF OMB N	ED: 02/21/2014 RM APPROVED IO, 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED			
	245360				0:	02/05/2014		
	ROVIDER OR SUPPLIER	Y OF NEW LONDON		100 G	ET ADDRESS, CITY, STATE, ZIP CODE GLEN OAKS DRIVE V LONDON, MN 56273			
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F 315	Continued From page	ə 16	F	315				
	9/16/13- "Resident w amount of urine, PVF bladder. No skin issu	as incontinent of small < done, 238 ml present in ues noted.''						
	was over 200 ml. Pu every shift until Frida Inhysician] Difficult	checked residents last PVR It resident on PVR checks y and will address with to tell if resident had just resident does not voice when he bathroom."						
		No complaints of pain" VR for 423. Abdomen soft."						
	9/19/13- "Abdomen in been PVR for 620 m and then rechecked void. Abdomen palp Updated [hospice] w her up and see if she does not or voids ve catheter] per hospice was assisted onto co approximately 100 c	noted to be distended. Had I. Staff waited for an hour to see if she had voided. No pated with discomfort noted. the stated to attempt to get e can void on the toilet. If she ry little can insert a [urinary e standing orders. Resident formode. She voided ac. Urinary catheter was of brown, foul smelling, a. At the end of the cathing						
	manager (CM)-A sta catheter placed rela per hospice standin was unable to provi PVR's or urinary ret from 9/19/13. CM-/	2/5/14, at 9:55 a.m. clinical ated R13 had a urinary ted to comfort and high PVR's g orders. CM-A stated she de any documentation of high rention except the charting A verified R13 had a significant n condition at that time and	2544	Eacil	Ity ID: 00314	If continuation	sheet Page 17 of	

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	TMENT OF HEALTH AN <u>RS FOR MEDIC</u> ARE &				PRINTED: 02/21/2014 FORM APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
	-	245360	B. WING		02/05/2014
	PROVIDER OR SUPPLIER	Y OF NEW LONDON		STREET ADDRESS, CITY, STATE, ZIP CODE 100 GLEN OAKS DRIVE NEW LONDON, MN 56273	
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F 323 SS=G	treated for a urinary tr 2013. R13 had been the beginning of Janua gain and improvement CM-A verified the facil remove the indwelling though R13's condition the current diagnoses of vaginitis with skin bi- diagnoses for ongoing catheter. Although R13 had an i status, they had not re catheter to determine i ongoing high PVR's or facility did not attempt catheter in 5 months, s if R13 continued to nee catheter. A policy on urinary cath requested but not prov 483.25(h) FREE OF AC HAZARDS/SUPERVIS The facility must ensure environment remains a as is possible; and eac	act infection in August discharged from hospice at ary 2014 related to weight t in her health condition. ity had not attempted to urinary catheter even n had improved, nor was provided by the physician reakdown an appropriate use of a indwelling f she had continued urine retention. The to remove the urinary ince insertion to determine ed a indwelling urinary neter justification was ided. CCIDENT ION/DEVICES e that the resident s free of accident hazards	F 3	<ul> <li>The facility ensures that th environment remains as from hazards as is possible.</li> <li>a. Care plan has been upda impervious clothing protect as well as covered cups wh</li> </ul>	ee of accidents ated to include a fluid stor on chest and lap

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	CONNECTION		A. BUILD	ING				
		245360	B. WING	P		02/	05/2014	
NAME OF PI	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE			
BENEDIC	TINE LIVING COMMUN	ITY OF NEW LONDON			00 GLEN OAKS DRIVE EW LONDON, MN 56273			
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		на и на при н	_		b. Residents that were previo	ously using	covere	
F 323	Continued From page		F	323	cups for hot liquids are now also using fluid			
	This REQUIREMENT is not met as evidenced by:				impervious clothing protectors to prevent spill			
	Based on interview facility failed to conc			from permeating to their skin.				
	implement intervent			c. Coffee and Cocoa machines have been move				
	potential for burns from coffee after 2 of 3 residents (R7 and R59) had sustained burns from spilled hot beverages, resulting in actual harm for				into the Dietary department for closer			
					supervision of these hot items. Thermostats of			
	R7 when burns were addition, Furthermo			the beverages have been lowered to 140				
	fall interventions we			degrees. Light tan colored cups are being used				
	(R45) reviewed for f			so residents can see the level of coffee in the				
	Findings include:			cups. Fluid impervious adaptive clothing				
	R7 sustained secon	R7 sustained second degree burns from spilled						
	hot coffee on 11/23/	13, the facility failed to ions to prevent further burns			protectors, covered cups, and spout cups are			
		13, R7 sustained another			being used for those resident			
	second degree burn	second degree burns from spilled hot coffee,			difficulty with fine motor dexterity. Resider			
	resulting in actual harm.			are assessed on an on-going				
	R7's significant char	''s significant change Minimum Data Set (MDS)			or SLP. Dining Room Commit			
	dated 11/18/13, incl			monthly and reviews and add		-		
		arthritis. The MDS indicated R7 had severe itive impairment and required extensive			concerns they see in the Dining Room. Facility			
	assistance with eati	nce with eating/drinking. The cognitive			incident report has been updated to include a			
	loss/dementia Care Area Assessment (CAA) dated 11/13/13, indicated R7's cognition varied				evised Fall Scene Investigation with			
	considerably from b	erably from being alert and oriented to ely confused. The ADL (activities of daily functional/rehabilitation potential CAA 11/13/13, indicated R7 was declining in			intervention to prevent recurrence. In-service			
	extremely confused.				to staff on 3/5/2014 and 3/6/	o staff on 3/5/2014 and 3/6/14.		
	living) tunctional/reh dated 11/13/13. indi			,				
	condition and started end of life hospice care.				d. Dietary monitors temperature of hot			
	D7's agree blan data	R7's care plan dated 1/21/14, identified R7			beverages daily prior to meals. RN Managers will perform monthly audits of restorative			
	needed assistance	with meals and			•			
	encouragement with			needs/ adaptive equipment use of their				
	to be covered with li of spilling hot liquids	ds related to resident's history			residents, completion of incid	ient repor	ts, and	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/21/2014 FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		245360	B, WING		02/05/2014	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	nyaan (ny Caymood an Anna an An	
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		100 GLEN OAKS DRIVE NEW LONDON, MN 56273		
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F 323	Continued From page	a 10	F 32	report findings to Quality Assurance commi		
1 020	Commueur rom page	5 10		Director of Nursing respon	sible.	
	When interviewed on 2/5/14, at 9:30 a.m. the assistant director of nursing (ADON) stated R7 could independently drink fluids, including hot			e. Correction Date 3/5/201	.4	
	beverages.					
	indicated R7 had spi 11/22/13, in the facilit 0.5 c.m. (centimeter) thigh. The blister was According to the incic immediately applied t	nt Report, dated 11/23/13, lled coffee on her lap on y dining room and sustained blister on her right inner i intact with no redness. lent report, an ice pack was to the burned area. No hs were implemented after her thigh.				
	3:00 p.m. included R with her coffee cup in stated, "I'm sorry, I fe crying a few minutes her right inner thigh, I 0.2 cm X 4 cm and 0. were open. An ice pa Additionally Mepiliex absorbs wound fluid) The physician was co Silvadene ointment (a treat and prevent bac and third degree burr daily. Staff were inst liquids-Required."	(a soft foam dressing that was applied to the area.				
	R7's progress note da blister area to the righ	ated 12/4/13, indicated the nt inner thigh measured a				

		ID HUMAN SERVICES					FORM APF	ROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				OMB NO, 0938-0391 (X3) DATE SURVEY COMPLETED		
		245360	B. WING_				02/05/20	)14	
	ROVIDER OR SUPPLIER	Y OF NEW LONDON		100 G	ET ADDRESS, CITY, STATE, ZIP SLEN OAKS DRIVE VLONDON, MN 56273	CODE			
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	וD PREFIX TAG	<b>K</b>	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	TION SHOULD B THE APPROPRI	-	(X5) IPLETION DATE	
F 323	Continued From page total of 10 cm X 3 cm smaller blisters that we edges. The large blis beefy red area noted Although R7 had two second degree burns not assessed her to c handle hot beverages current temperature. R59 sustained redner chocolate on himself not implement measu and on 10/10/13, R56 where hot chocolate caused burns to skin R59's quarterly MDS diagnosis of dementi impairment, and requ person physical assis R59's care plan date cups for all fluid espe and assist with meal	a 20 and there were additional 2 vere intact on the outer ster had opened and had to the wound bed. separate incidents of from coffee, the facility had determine if she could safely a independently at the ss to skin from spilling hot on 10/9/13, the facility did ures to prevent burns for R59 9 sustained another incident was spilled which could have dated 1/6/14, included a a, severe cognitive uired supervision and one stance with eating/drinking. d 1/6/14, identified cover ecially hot fluids, set up tray as needed.	F3	323	DEFICIEN				
	5:30 p.m. included R from hot chocolate w interventions were pl not spill hot liquids of additional burns.	ent Report dated 10/9/13, at 59 had sustained a burn hile in the dining room. No aced to ensure R59 would n himself again and suffer							
	R59 dropped his hot thighs. He sustained	s dated 10/9/13, indicated chocolate onto his upper slight redness to the area blistering. An ice pack was			سراير (شراير)		uation sheet Pag	- 04 -5 00	

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Event ID: TP0511

Facility ID: 00314

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					ONIR NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		245360	B. WING				02/05/2014
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BENEDIC	TIME LIVING COMMONT			N	IEW LONDON, MN 56273		، • • • • • • • • • • • • • • • • • • •
(X4) ID PREFIX TAG			ID PREFIX TAG		(EACH CORRECTIVE / CROSS-REFERENCED 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 323	applied. R59's Resident Incide at 5:15 p.m. indicated chocolate onto his lay on the, "burned area were red but the redr (bedtime)." As resul recommended all liqu Although R59 had tw spilling hot chocolate assessed him to dete handle hot beveraged When interviewed on director of nursing (D R7 and R59, had all liquids. The DON add assessed to require of containers, but was r the 2nd incidents. Temperatures of the with the DM on 2/5/1 Cafitesse 3000 autor dispenser was found room, which served 4 cognitive and mobility estimated 40 of the red drinking hot beveraged checked the tempera and the coffee was 1 the decaffeinated cof water was 163 degree degrees F. A facility policy dated Equipment, identified	ent Report dated 10/10/13, d R59 again spilled hot p. An ice pack was placed of his thighs." His thighs ness was, "gone by HS it of the second incident, staff uids should have covers. To separate incidents of r, the facility had not ermine if she could safely s independently. a 2/5/14, at 11:45 a.m. the OON) stated she was aware sustained burns from hot ded that R7 and R59 were covers on their hot beverage not implemented until after hot beverages were tested 4, at 11:51 a.m. The matic coffee/hot liquid in the open main dining 43 residents of varying y impairment levels. The DM esidents were capable of es independently. The DM ature of the hot beverages 61 degrees Fahrenheit (F), ffee was 169 degrees F, hot are F and hot cocoa was 147	F	323		ENCY)	
	a president and the second second in the second		511	Fo	cility ID: 00314	If continu	ation sheet Page 22 of 29
FORM CMS-256	67(02-99) Previous Versions Ob	solete Event ID: 1P0	911	га		n continu	

CENTER STATEMENT ( AND PLAN OF NAME OF P	S FOR MEDICARE & OF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER TINE LIVING COMMUNIT SUMMARY ST. (EACH DEFICIENC	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245360 Y OF NEW LONDON ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		NG ST 100 NE	CONSTRUCTION REET ADDRESS, CITY, STATE, ZIP CODE O GLEN OAKS DRIVE EW LONDON, MIN 56273 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	FORI OMB NC (X3) DATE COMI 02	D: 02/21/2014 M APPROVED D. 0938-0391 SURVEY PLETED /05/2014 (05/2014
F 323	staff." The procedure limited and fine motor hands/arms, at risk for the appropriateness of prevent spills" R45 had sustained five take herself to the toi ensure staff assisted appropriate foot wear plan. R45's admission Mini 11/28/13, identified the impairment, required	ensed nursing and therapy a includes, "Resident with r skills or tremoring of the or spills, will be assessed for of covered cups for liquids to ve falls while attempting to let. The facility failed to her to the toilet, and used as directed by her care mum data set (MDS) dated he resident had no cognitive extensive assistance with istory of falls prior to and	F3	23			
	was observed walking transfer belt being as nursing assistant (NA quickly and had a slig R45's care plan dated resident was at high dependence on staff impaired cognition, m at home. The care p was independent with ambulation, locomoti- out of room "dependi and resident was to v on at all times. R45's	n 2/4/14 at 9:19 a.m. R45 g in the hallway wearing a sisted by an [unknown] .). The resident was walking ght shuffle when she walked. d 12/30/13 identified the risk for falls related on for transfers and toileting, nedications, and many falls lan indicated the resident n bed mobility, transfers and on in wheelchair in room and ng on residents condition," vear grippy socks or shoes a toileting plan included tly incontinent of urine, with ren during the night.					

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

Event ID: TP0511

Facility ID: 00314

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PRINTED: 02/21/2014

		& MEDICAID SERVICES			(X3) DATE	0. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLETED
		245360	B. WING		02/	05/2014
NAME OF PI	ROVIDER OR SUPPLIER	анна и <mark>на на н</mark>		TREET ADDRESS, CITY, STATE, ZIP CODE 00 GLEN OAKS DRIVE		
BENEDIC <sup>-</sup>	TINE LIVING COMMUN	NITY OF NEW LONDON	1	IEW LONDON, MN 56273		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
			F 000			
F 323		age 23 sted to include staff assist to	F 323			
	toilet on routine nig instructed staff to a	ht rounds. The care plan assist to the bathroom every t rounds, and make sure to				
	wake on 4:00 a.m. request.	rounds and as needed per her				
	Upon review of R4 Incident Report ind	5's falls on the Resident licated the following:				
	butt in bathroom. I to bathroom and sl regular socks on fe intervention identifi socks" were on at	m "Resident found sitting on Resident stated she was going lowly slipped to floor had pet." The immediate ied was to ensure "grippy night. The incident report ent had last been toileted s."				
	registered nurse (F toileting program o hours. RN-B state according when the toileted, however, between 5:30 a.m.	n 2/5/14, at 5:15 p.m. RN)-B stated R45 was on a of being toileted every two d there was no way to tell e resident had last been she had assumed it had been and 6:00 a.m., as that is when Jsually,'' completed.				
	her buttocks in bat was backing up to soon" The resid socks at the time. that time was to re assistance if she.	.m "Resident found sitting on hroom floor and states she the toilet and sat down too ent was only wearing regular The immediate intervention at mind resident to ask for 'feels she needs it," and to ilet before sitting down. There		·		

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Event ID: TP0511

Facility ID: 00314

If continuation sheet Page 24 of 29

PRINTED: 02/21/2014 FORM APPROVED OMB NO 0938-0391

STATEMENT C	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		NSTRUCTION		ATE SURVEY DMPLETED
		045260	B. WING	" head to be a set of the set of			10/05/2044
	ROVIDER OR SUPPLIER	245360 TY OF NEW LONDON	B. WING	100 G	ET ADDRESS, CITY, STATE, ZIP CODE GLEN OAKS DRIVE / LONDON, MN 56273		02/05/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 323	Continued From page is no indication of wh been assisted with to	en the resident had last	F	323		•	
	stated R45 was remi that time. RN-B verit	2/5/14, at 5:15 p.m. RN-B nded to ask for assistance at fied there was no indication had last been assisted to the					
	Sitting on her bottom in a sitting position wearing socks at tim intervention at this tii	ne was to wear gripper times. The incident report					
	12/30/13, at 3:35 p.m resident room appro- reports resident havi continued to have er Resident noted to have p.m. where she hit h started at 2:00 p.m. blood pressure went noted temperature w amount of time. No and at 3:15 p.m. res to right side of back room (ER)" Follow 12/30/13 at 6:46 p.m nurse indicated them	Progress Note dated n. indicated, "Writer called to ximately 3:15 p.m. with ing emesis. Resident mesis with dry heaves. ave fall approximately 2:00 er head on the toilet. Neuros and it was noted her systolic t from 118 to 160-170's. Also yent from 97-98.7 in a short injuries noted at time of fall ident noted to have swelling of head send to emergency v up Progress Note on n. from the emergency room e were no findings at the ER id to the facility that evening.					
	During interview on	2/5/14, at 5:15 p.m. RN-B					

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				T	IO, 0938-039
TATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN			'E SURVEY IPLETED	
		245360	B. WING			0	2/05/2014
NAME OF PI	ROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE	. •	
BENEDIC	TINE LIVING COMMUNI	TY OF NEW LONDON			EN OAKS DRIVE LONDON, WN 56273		
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES TO 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 323	stated R45 toileted h for help. RN-B state	e 25 erself and often did not ask d R45 should have been toileting every 2 hours.	F 3	23			
	call light at 7:50 a.m resident was sitting of walker in front of her tangled up in her be bathroom." Resider	It had bare feet at the time of t report indicated the resident					
	stated R45 had bee every two hours and times. RN-B verified not been toileted sir minutes before the f not have any grippe	2/5/14, at 5:15 p.m. RN-B n care planned to be toileted I have gripper socks on at all d the report indicated R45 had nee 3:00 a.m., 4 hours and 50 all, and also the resident did r socks on as care planned. d no further information had not been done.					
	room between bath doorslipped onto l socks at the time of indicated the reside	bottom wearing regular the fall." The incident report nt was last toileted and off" and "needed gripper socks					
•	stated she was uns	2/5/14, at 5:15 p.m. RN-B ure why the resident had not not have gripper socks on at RN-B stated R45 had been					

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		245360	B. WING		02/	05/2014	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO			
				100 GLEN OAKS DRIVE			
BENEDIC	TINE LIVING COMMUNIT	Y OF NEW LONDON		NEW LONDON, MN 56273			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 323	Continued From page	26	F 32	3			
	assessed as needing						
	assistance every two						
		y be just checking on the					
		ning of their shift to see if the					
	resident is strong end	ough to toilet herself that day.					
	During interview on 2	/4/14, at 9:13 a.m. nursing					
		ed R45 can be independent					
		f will ask her if she feels					
		If she is weak staff will					
	assist her with toiletin	g.					
	stated staff will check	/4/14 at 9:43 a.m. NA-A with resident about every she feels in regards to			•		
·	Although all of R45's toileting, the facility fa	falls were related to self niled to ensure the fall rere put in place were being te.					
	A facility fall policy wa	as requested but not					
	provided.						
F 356		IURSE STAFFING	1 + 35	<sup>6</sup> a., b., c., A new Daily Sta	affing Totals form	n has	
SS=C	INFORMATION			been developed. It is th	e responsibility c	of the	
	The facility must post	the following information on		Staffing Coordinator/ He			
	a daily basis:						
	o Facility name.			to complete and post th	is form including	5	
	o The current date.			Census.			
		nd the actual hours worked	-				
		pories of licensed and					
	unlicensed nursing st	aff directly responsible for					

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

Event ID: TP0511

Facility ID: 00314

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 02/21/20 /I APPROV ), 0938-03
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245360	B. WING			02/	05/2014
	ROVIDER OR SUPPLIER	Y OF NEW LONDON	<u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>	11	TREET ADDRESS, CITY, STATE, ZIP CODE 00 GLEN OAKS DRIVE EW LONDON, MN 56273		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) . COMPLETI DATE
F 356	resident care per shif - Registered nurs - Licensed practic vocational nurses (as - Certified above on a of each shift. Data m o Clear and readable o In a prominent place residents and visitors The facility must, upor make nurse staffing of for review at a cost n standard. The facility must main required by State law This REQUIREMENT by: Based on observation interview, the facility staffing information p days of the week. Th 53 of 53 residents, fa visitors who may cho Findings include: During observation of	t: es. :al nurses or licensed · defined under State law). aides. : the nurse staffing data daily basis at the beginning iust be posted as follows: format. e readily accessible to	F	356	one month or until sustained co achieved as evidenced by 7 con completion, then quarterly thro e. Monitoring will be the respon Staffing Coordinator or designed Corrected 2/7/2014	omplianc secutive ough 201 nsibility c	e is days of 4. of the

PRINTED: 02/21/2014 FORM APPROVED OMB NO: 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			An		<u>J. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		E SURVEY PLETED
		245360	B, WING	-		02	/05/2014
NAME OF PI	ROVIDER OR SUPPLIER	and a second	a ferrande en de la f		ET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC.	TINE LIVING COMMUNIT	Y OF NEW LONDON		1	GLEN OAKS DRIVE ( LONDON, MN 56273		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	Continued From page was hanging in the w station. The nursing and visitors were date back of the posting w 2/2/13 to 2/5/14 but th to residents or visitors When interviewed on facility scheduler (FS nurse staffing informa- time. She fills in the actual hours of nursir to ensure the posting day during week days do this on the weeken When interviewed on director of nursing (D The assistant directo reported on 2/5/13, a	2/4/13, at 2:10 p.m. the onds.		356			
	57(02-99) Previous Versions Obs	solete Event ID: TPi	0511	Facility	ID: 00314 If con	ntinuation she∢	et Page 29 of 29
FURINI UNIS-250	DI (02-39) FIGNIOUS VEISIONS ODS						-

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS ING 01 - MA	AIN BUILDING 01		ATE SURVEY OMPLETED
		245360	B, WING				2/04/2014
	PROVIDER OR SUPPLIER	UNITY OF NEW LONDON		100 GLE	ADDRESS, CITY, STATE, ZIP EN OAKS DRIVE ONDON, MN 56273		
x4) ID REFIX TAG	JEACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIC DATE
K 000	INITIAL COMMEN	TS	K	000			
	FIRE SAFETY				DIC M		
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT T PAGE OF THE CM	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST 4S - 2567 FORM WILL BE CATION OF COMPLIANCE.		10	PIC M PR 3-28-14		
	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN VITH YOUR VERIFICATION.					
	Minnesota Depart Fire Marshal Divis Benedictine Living was found not in s requirements for p Medicare/Medicai 483.70(a), Life Sa edition of National	d at 42 CFR, Subpart fety from Fire, and the 2000 I Fire Protection Association 101, Life Safety Code (LSC),			RECEIV	EP	
	DEFICIENCIES T	OR THE FIRE SAFETY O:			MAR 2 8 20	SAFETY	
	STATE FIRE MAI 444 CEDAR STR ST. PAUL, MN 55	5101-5145, or			STATE FIRE MARSHAL	DIAIOION	(X8) DATE
BORATO	RY DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	Akin	TITLE	3	1 .1

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

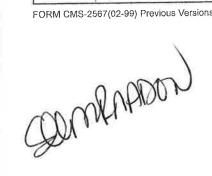
-

Event ID: TP0521

Facility ID 00314

If continuation sheet Page 1 of 4

		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 02/21/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - Main Building 01	(X3) DATE SURVEY COMPLETED
		245360	B. WING		02/04/2014
NAME OF F	ROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP	CODE
BENEDIO	CTINE LIVING COMM	UNITY OF NEW LONDON		00 GLEN OAKS DRIVE NEW LONDON, MN 56273	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
K 000	Continued From pa	ge 1	K 000		
	By e-mail to: Marian.Whitney@s	tate.mn.us			E.
<i>fil-l</i> .	DEFICIENCY MUS				
3-17-	to correct the defici				
		oposed, completion date.			
Ś	3. The name and/o responsible for com prevent a reoccurre	r title of the person rection and monitoring to ence of the deficiency.			
hl	a 1-story building w building was constru- original building was determined to be o	Community of New London is with a partial basement. The ructed at 4 different times. The is constructed in 1964 and was f Type II(000) construction. In was added to the south of the			
	Service Wing that II(000) construction added to the north determined to be o 1999 and addition 1993 addition that	was determined to be of Type n. In 1996 and addition was of the Service Wing that was f Type II(000) construction. In was added to the south of the was determined to be of Type		MAR 1 0 20	<b>ED</b> 014
EXIT	and the 3 additions	<ul> <li>Because the original building are of the same type cility was surveyed as one</li> </ul>		MN DEPT. OF PUBLIC STATE FIRE MARSHAL	SAFETY DIVISION
	system. The facility smoke detection in	y protected by a fire sprinkler y has a fire alarm system with the corridors and spaces or that is monitored for s Obsolete Event ID: TP052		acility ID: 00314	If continuation sheet Page 2 of



		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - Main Building 01		E SURVEY PLETED
		245360	B, WING			02/	04/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE LIVING COMM	UNITY OF NEW LONDON			EW LONDON, MN 56273		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPN DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	automatic fire depa has a licensed capa census of 53 at the The requirement at	rtment notification. The facility acity of 62 beds and had a time of the survey. 42 CFR Subpart 483.70(a) is	KC	000	2		
K 056 SS=F			κc	056	Grace Living Community of Glen automatic sprinkler system has 2 of sprinkler heads that meet the under code standard NFPA 101. of sprinkler heads will be kept by maintenance department on an Extra sprinkler heads have been both styles. Correction Date: 3/21/14 The sprinkler gauges located on sprinkler have been replaced. Maintenance Director will monit compliance and is responsible for necessary Correction date 3/7/2014	differe require 2 of ea 7 the on-goin ordered the mai	ment ch kind g basis. d for in fire
	Based on observa system is not instal accordance with NI Installation of Sprin to maintain the spri with NFPA 13 (99) out of service caus protection system of				cility ID: 00314		eet Page 3 of 4

PRINTED: 02/21/2014

		AND HUMAN SERVICES				FORM	APPROVED
STATEMENT		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '	IPLE CONSTRUCTION		(X3) DATE	0938-0391 SURVEY PLETED
		245360	B. WING			02/(	04/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CIT		ULI	
BENEDIC	CTINE LIVING COMM	UNITY OF NEW LONDON		100 GLEN OAKS DRIN NEW LONDON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	S PLAN OF CORRECTI ECTIVE ACTION SHOUL ENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
K 056	Continued From pa	ige 3	K 0!	56			
	02/04/2014, observ	veen 10:00 AM to 1:00 PM on rations reveled the following were found affecting the er system:					=
	equipped with at lea sprinkler heads tha The observed miss were the same type	ler head box was not ast 2 of every type and style of t are being used in the facility. ing spare sprinkler heads as the ones located in the and spare sprinkler head box					
	2. The sprinkler ga sprinkler riser have since 2008.	uges located on the main fire not been tested/replaced					i i
	These deficient pra Maintenance Super	nctices were verified by the rvisor (BN).					
				2			
			The second			s	
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID: TP052	1	Facility ID: 00314	lf conti	nuation shee	et Page 4 of 4

PRINTED: 02/21/2014



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8224

February 21, 2014

Mr. James Laine, Administrator Benedictine Living Community Of New London 100 Glen Oaks Drive New London, Minnesota 56273

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5360025

Dear Mr. Laine:

The above facility was surveyed on February 2, 2014 through February 5, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Benedictine Living Community Of New London February 21, 2014 Page 2 and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 3333 W Division, #212 St Cloud Mn 56301. 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 at (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 Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         00314         NAME OF PROVIDER OR SUPPLIER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED	
		00314					
		ADDRESS, CITY, STATE, ZIP CODE		02/05/2014			
BENEDIC			EN OAKS DRIVE				
	TINE LIVING COMMUNI	IY OF NEW LONDON NEW LC	NDON, MN 562				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES					
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	n pe	(X5 COMPL DAT	
2 000	Initial Comments		2 000				
	*****ATTEN	TION*****					
. I	NH LICENSING CO	ORRECTION ORDER					
:	144A 10 this correct	innesota Statute, section on order has been issued					
	pursuant to a survey,	If upon reinspection, it is			· · ·	۰.	
	tound that the deficier	ICV OF deficiencies cited					
	herein are not correcte	ed, a fine for each violation	-	-	-		
	with a schedule of fine	assessed in accordance s promulgated by rule of					
:	the Minnesota Departr	nent of Health.					
	Determination of whet	her a violation has been			:		
	corrected requires con	pliance with all					
י <sub>.</sub> ا	requirements of the rul	e provided at the tag number indicated below.					
1	When a rule contains s	everal items, failure to			:		
, C	comply with any of the	items will be considered					
	ack of compliance. La	ck of compliance upon			1		
; r	esult in the assessment	tem of multi-part rule will nt of a fine even if the item			:		
: ti	hat was violated during	the initial inspection was					
C	corrected.				1		
Υ.	′ou may request a hea	ring on any assessments					
; tr	hat may result from no	n-compliance with these			:		
th	nders provided that a v ne Department within 1	vritten request is made to					
n	otice of assessment fo	r non-compliance.			•		
IN	VITIAL COMMENTS:						
: 0	n February 2, 3, 4, and	5th, 2014, surveyors of		Minnesota Department of Health is	:		
th	iis Department's staff,	visited the above provider		documenting the State Licensing	1 :		
· W	nd the following correct hen corrections are co	tion orders are issued. Impleted, please sign and	• (	Correction Orders using federal softwar	e.		
da	ate, make a copy of the	se orders and return the		lag numbers have been assigned to			
on	iginal to the Minnesota	Department of Health	H	Ainnesota state statutes/rules for Nursir Tomes.	Ig		
Dr	vision of Compliance N	Aonitoring, Licensing and		······			
ta Departn TORY DIRF	nent of Health	PLIER REPRESENTATIVE'S SONATURE				·	
	I PARTA			Ad TITLE	(X6) D	ATE, r	
ORM	1 VIND	- Le Marst	4	TARM IS SALDR	5/18	\$1/4	

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