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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: TP05

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00314

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245360**

2.STATE VENDOR OR MEDICAID NO.
(L2) **448348100**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY OF NEW LONDON**
(L4) **100 GLEN OAKS DRIVE**
(L5) **NEW LONDON, MN** (L6) **56273**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2011**

6. DATE OF SURVEY **04/03/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **62** (L18)

13.Total Certified Beds **62** (L17)

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	62			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Tim Rhonemus, HFE Ne II — 4/17/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 04/30/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/07/2014
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA MDH DEPARTMENT OF HEALTH

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,

Kate Johnston

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245360	A. Building B. Wing	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) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **03/06/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **03/06/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/01/2014**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **03/05/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **03/05/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **02/07/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	4/18/2014	20794	4/3/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/5/2014			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00314	A. Building B. Wing	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) Item	(Y5) Date
ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp. 2** LSC	Correction Completed **03/01/2014**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **03/05/2014**	ID Prefix **20910** Reg. # **MN Rule 4658.0525 Subp. 5 A.I** LSC	Correction Completed **03/05/2014**
ID Prefix **21990** Reg. # **MN St. Statute 626.557 Subd. 4** LSC	Correction Completed **03/06/2014**	ID Prefix **22000** Reg. # **MN St. Statute 626.557 Subd.** LSC	Correction Completed **03/06/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	4/18/2014	20794	4/3/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/5/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245360	A. Building B. Wing 01 - MAIN 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	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 03/21/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KJ	4/18/2014	27200	4/10/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/4/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TP05

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00314

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245360**

2.STATE VENDOR OR MEDICAID NO.
(L2) **448348100**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY OF NEW LONDON**
(L4) **100 GLEN OAKS DRIVE**
(L5) **NEW LONDON, MN** (L6) **56273**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2011**

6. DATE OF SURVEY **2/5/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **62** (L18)

13.Total Certified Beds **62** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	62			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jessica Sellner, HFE NE II 3/28/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 04/06/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA MDH DEPARTMENT OF HEALTH

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:

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

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

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

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

<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

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. 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,

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

Grace Living Community of GlenOaks

Benedictine Health System

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

April A Anderson RN DON
3/14/14

3/14/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____ MN Dept of Health St.Cloud	02/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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F 000	INITIAL COMMENTS The 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 verifcation 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 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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 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	F 225	The facility ensures that all allegations of abuse 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 I don't know where he gets those ideas." Most recent BIMS score for R22 is 15 indicating cognitively intact. DON interviewed the male orderly identified 2/2/2014 and immediately directed that no male staff go into that room to give care. R 18 Care Plan Problem: "Known to stretch the truth" Approach: Allow to vent Re: clarify events and complaints to make sure truth is clear." Most recent BIMS score for R18 was 12	

3/14/14 Del addendum to POC BT

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shelly Ohmer ADON | TITLE: ADON | (X6) DATE: 3-7-14

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.

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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were immediately reported to the state agency (SA), were thoroughly investigated, and failed to implement measures for resident protection during an investigation for 2 of 6 resident (R18 and R35) allegations of abuse, and neglect. Findings include: R18 made an allegation that R22 had been abused by a staff member. The facility failed to report the allegation to the state agency, and investigate this allegation of abuse. R18's quarterly Minimum Data Set (MDS) dated 12/11/13, included moderate cognitive impairment, had no delusions or behavior problems. When interviewed on 2/2/14, at 2:03 p.m. R18 stated, "He sexually assaulted my wife [R22]." R18 went onto explain an unknown "male care	F 225	indicating moderately cognitively impaired. Review of interdisciplinary progress notes reveals numerous occasions of R18 voicing concerns that were determined to be false and voicing concerns related specifically to male residents. Following investigation related to a concern in the past, R18 stated to SW, "Maybe I stretched the truth a little." Interviews with Licensed staff and NAR'S, Physical Therapy and Occupational Therapy who work with this couple often completed 2/2 through 2/6. Resident had not voiced this concern to staff to their knowledge prior to voicing it to surveyor on 2/2/14. Incident with R5 and R35 was investigated internally. The two residents met with staff present to talk about this incident, and are cordial to each other. R35 has moved to a different table in the Dining Room, but these two residents continue to engage socially with each other. b., c., Policies and procedures have been updated to hybrid the federal and state regulations. Facility incident reports have been updated to include determination of willful intent for resident to resident altercations with determination re: whether the incident is	

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F 225	Continued From page 2	F 225		

giver" had been touching R22 inappropriately about a week ago. "He's a filthy beast, he is nothing but a uh uh beast." R18 stated he had reported this to a, "Head nurse," last week, but was unsure who the nurse was and nothing had been completed. "They didn't understand me, and didn't take me seriously."

R22's quarterly MDS dated 1/8/14, included she was cognitively intact. When interviewed on 2/2/14, at 2:15 p.m. R22 stated she had not been "sexually assaulted" and R18, "Has always been jealous." She verified staff had not asked her anything about this allegation made by R18.

When interviewed on 2/2/14, at 2:50 p.m. the assistant director of nursing (ADON) stated she was not aware of any allegation made by R18 about R22. The allegation was reported by the surveyor to the ADON 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.

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F 225	Continued From page 3 When interviewed on 2/4/14, at 1:03 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 though 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). 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, "Altered perception." There were no measures taken to protect R22 as no investigation had been started. The DON would report it to the SA and start an investigation now, three days after the allegation was reported to the ADON. When interviewed on 2/5/14, at 11:00 a.m. the administrator stated there was, "Some talk," 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. Review of R18's progress notes from 10/1/13 through 2/4/14 did not identify any, "altered perception," delusions or inappropriate behavior. Also, there was no indication in the record that an investigation had been started by the facility regarding R18 allegation of abuse to R22. Even though R18 had made allegations of abuse by a "male care giver" towards R22, "about a	F 225	reportable to the SA. Mandatory in-services have been held for staff and will be on-going to capture on-call staff, regarding these updates. New staff will be orientated to these policies and procedures at time of hire. d. Incident reports will be audited for completion weekly with results reported to Quality Assurance Committee. e. Corrected 3/6/14. Administrator responsible.	

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F 225	Continued From page 4 week ago. " The allegation was again reported to the facility on 2/2/14, but the facility failed to report the allegation to the SA, did not act on the allegation to investigate the alleged abuse of R22, nor had the facility protected R22 during their investigation. 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. R5's progress note dated 1/29/14, indicated, "Resident [R35] was ambulating into DR [dining room] for lunch and her walker bumped [R5's] w/c [wheel chair] and [R5] was saying, 'I'm so sick and tired of people bumping me', kept pushing resident [R35] sideways and writer caught resident just as she was about to tip over." When interviewed on 2/5/13, at 9:09 a.m. LPN-B stated she had witnessed R5, "Intentionally," back her wheel chair into R35, on 1/29/14. R35 had not actually fallen or been injured, but was visibly shaken and upset that her table mate would attempt to knock her over. LPN-B stated she did not think this was a reportable incident and had not reported it. R35's quarterly MDS dated 1/24/14, included	F 225		

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F 225	Continued From page 5 intact cognition and utilized a walker for ambulation. When interviewed on 2/5/13, at 5:05 p.m. RN-B stated she had reviewed the incident, between R5 and R35. Since R35 had not sustained any injuries, this was not a reportable event to the SA, nor had they completed any incident report or investigation of the incident. RN-B stated she however reported the incident to SS-A. When interviewed on 2/5/14, at 5:14 p.m. SS-A stated she was aware of R5 backing her wheelchair into R35, but had not reported it or investigated further because no one had sustained any injuries. "They were nit-picking with each other." When interviewed on 2/5/14, at 5:27 p.m. the DON stated she didn't feel R35 really wanted to harm R5, therefore the incident had not been investigated or reported to the SA. The DON stated they should have reported it to the SA and investigated the incident further to determine if resident to resident abuse had occurred. An undated Glen Oaks Care Center Vulnerable Adult Policies Components of the Abuse Program, included an immediate investigation, protection of the resident, and immediate reporting of allegations of abuse. An undated Abuse Investigation Policy, included an interview of the person reporting abuse would occur, and staff would be interviewed. Accused employees would be barred from further contact with the resident during an investigation.	F 225		
F 226	483.13(c) DEVELOP/IMPLMENT	F 226		

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F 226 SS=D	Continued From page 6 ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced 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 (R22 and R35) allegations reviewed. In addition, the facility abuse prohibition policies failed to identify resident to resident abuse, or injures of unknown source. 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 to include resident to resident abuse or injuries of	F 226	a., b., c. The facility has updated policies and procedures to hybrid state and Federal guidelines on resident to resident altercations and for accident/ incident reporting. Vulnerable Adult reporting on these guidelines have been in-serviced to staff and it is on-going to capture on-call staff. New hires will be orientated to these policies and procedures at time of hire. d. Quality Assurance Committee will review reports and procedures being followed at monthly Quality Assurance Committee. Administrator Responsible e. Correction Date 3/6/2014	

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F 226	Continued From page 7 unknown source. During an interview on 2/5/14, at 5:27 p.m. the DON verified the facility's policy did not identify resident to resident altercations as potential abuse, unless there was an injury. The facility also was unable to find a definition of injuries of unknown source as part of their facility policy. R18 made an allegation that R22 had been abused by a staff member. The facility failed to report the allegation to the state agency, and investigate this allegation of abuse as identified by the facility policy. R18's quarterly Minimum Data Set (MDS) dated 12/11/13, included moderate cognitive impairment, had no delusions or behavior problems. When interviewed on 2/2/14, at 2:03 p.m. R18 stated, "He sexually assaulted my wife [R22]." R18 went onto explain an unknown, "Male care giver," had been touching R22 inappropriately about a week ago. "He's a filthy beast, he is nothing but a uh uh beast." R18 stated he had reported this to a, "Head nurse," last week, but was unsure who the nurse was and nothing had been completed. "They didn't understand me, and didn't take me seriously." R22's quarterly MDS dated 1/8/14, included she was cognitively intact. When interviewed on 2/2/14, at 2:15 p.m. R22 stated she had not been, "Sexually assaulted," and R18, "Has always been jealous." She verified staff had not asked her anything about this allegation made by R18.	F 226		

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F 226	Continued From page 8 When interviewed on 2/2/14, at 2:50 p.m. the assistant director of nursing (ADON) stated she was not aware of any allegation made by R18 about R22. The allegation was reported by the surveyor to the ADON 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. When interviewed on 2/4/14, at 1:03 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 though 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). 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, "Altered perception." There were no measures taken to protect R22 as no investigation had been started. The DON would	F 226		

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F 226	Continued From page 9 report it to the SA and start an investigation now, three days after the allegation was reported to the ADON. When interviewed on 2/5/14, at 11:00 a.m. the administrator stated there was, "Some talk," 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. Review of R18's progress notes from 10/1/13 through 2/4/14 did not identify any, "altered perception," delusions or inappropriate behavior. Also, there was no indication in the record that an investigation had been started by the facility regarding R18 allegation of abuse to R22. Even though R18 had made allegations of abuse by a "male care giver" towards R22, "about a week ago. " The allegation was again reported to the facility on 2/2/14, but the facility failed to report the allegation to the SA, did not act on the allegation to investigate the alleged abuse of R22, nor had the facility protected R22 during their investigation as directed by their abuse policies. 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 investigated the allegation of resident to resident abuse. R5's quarterly MDS dated 1/31/14, included moderate cognitive impairment and utilized a	F 226		

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F 226	Continued From page 10 wheel chair for mobility. R5's progress note dated 1/29/14, indicated, "Resident [R35] was ambulating into DR [dining room] for lunch and her walker bumped [R5's] w/c [wheel chair] and [R5] was saying, 'I'm so sick and tired of people bumping me', kept pushing resident [R35] sideways and writer caught resident just as she was about to tip over." When interviewed on 2/5/13, at 9:09 a.m. LPN-B stated she had witnessed R5, "Intentionally," back her wheel chair into R35, on 1/29/14. R35 had not actually fallen or been injured, but was visibly shaken and upset that her table mate would attempt to knock her over. LPN-B stated she did not think this was a reportable incident and had not reported it. R35's quarterly MDS dated 1/24/14, included intact cognition and utilized a walker for ambulation. When interviewed on 2/5/13, at 5:05 p.m. RN-B stated she had reviewed the incident, between R5 and R35. Since R35 had not sustained any injuries, this was not a reportable event to the SA, nor had they completed any incident report or investigation of the incident. RN-B stated she however reported the incident to SS-A. When interviewed on 2/5/14, at 5:14 p.m. SS-A stated she was aware of R5 backing her wheelchair into R35, but had not reported it or investigated further because no one had sustained any injuries. "They were nit-picking with each other." When interviewed on 2/5/14, at 5:27 p.m. the	F 226		

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F 226	Continued From page 11 DON stated she didn't feel R35 really wanted to harm R5, therefore the incident had not been investigated or reported to the SA. The DON stated they should have reported it to the SA and investigated the incident further to determine if resident to resident abuse had occurred.	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 residents (R60) who received dialysis at an outside unit, had a care plan developed to instruct staff on how to care for the dialysis resident.	F 279	The care plans describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. a. R60 's care plan was updated on 2/7/14 to reflect current services to the right IJ [internal jugular/chest area} for Dialysis. b. Care plans for other residents receiving dialysis were reviewed and are reflective of services being provided. c. A short-term care plan for dialysis via central line was created for newly admitted residents or residents with new onset of dialysis to be used prior to completion of Admission/ Significant Change in Status MDS assessments. RN Manager responsible for implementation on admission/ initiation of dialysis. d. DON/ADON to Audit Dialysis residents care plans for accuracy for all residents newly admitted/ new initiation of dialysis with results reported to the Quality Assurance Committee. e. Corrected 3/1/2014	

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	245360	A. BUILDING _____ B. WING _____	02/05/2014

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F 279	Continued From page 12 Findings include: R60's admission Minimum data set (MDS) dated 11/4/13, identified moderate cognitive impairment and required extensive assistance with all activities of daily living (ADL's) except eating. R60's care plan dated 2/3/14, identified the resident received dialysis at an outside facility on Monday, Wednesday, and Fridays. R60 was identified on the care plan as having a right IJ (interjugular/ in the chest area) tunneled catheter for dialysis. The care plan instructed staff regarding the care of the dialysis access site to, "monitor the access site for redness, bleeding pain, and swelling; Do not take blood pressure, give injections, or draw blood from arm with access in; no tight clothing, jewelry, or dressing should be worn on arm with access; monitor shunt every shift for presence of bruit and thrill; Notify doctor of possible occlusion of shunt such as: pain in extremity, fingers cool to touch and unable to feel the bruit through the shunt." The interventions identified in the care plan were for a resident receiving dialysis through an arm access, such as a fistula or shunt and not an IJ, which is located on the chest. During interview on 2/5/14 at 10:00 a.m. R60 stated she received dialysis at an outside facility on Monday, Wednesday, and Fridays through a right IJ catheter site in her chest. The resident stated the dialysis unit does all the care of the	F 279		

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F 279	Continued From page 13 access site, the facility does not have to do anything. On 2/5/14 at 10:00 a.m. R60's right IJ catheter was observed on her upper right chest area. The insertion site was covered with a clear bandage. During interview on 2/5/14, at 10:30 a.m. licensed practical nurse (LPN)-A stated R60 had a right IJ catheter for dialysis and the facility needed to ensure the catheter did not get wet or get pulled on. LPN-A verified the residents care plan was not correct, and the information contained on R60's care plan was for someone receiving dialysis through an arm access, such as a fistula or shunt. During interview on 2/5/14, at 7:05 p.m. assistant director of nursing (ADON) verified R60's care plan did not instruct staff on how to care for the residents IJ dialysis site and it was for a dialysis patient who received dialysis using an arm access. The undated facility policy titled Dialysis Renal Dialysis Program Guidelines, instructed staff to care for the external dialysis access site (IJ catheter) by monitoring for infection, avoiding excessive movement or manipulation of the catheter, and if the access pulls out to apply direct pressure for 10-20 minutes.	F 279		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

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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. 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. Findings include: 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. 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. R13's Progress Notes dated 1/24/14, indicated a fax was sent to the residents physician, "related to catheter was place when [R13] was started on	F 315	Based on a resident's comprehensive assessment the facility will ensure that our residents who have a catheter will have medical justification for the indwelling catheter. a. Catheter has been removed. b. All other residents with indwelling catheters have been reviewed for appropriateness of continued use of catheter. c. Continued need for hospice initiated devices and medications will be reviewed with the Significant Change in Status MDS following hospice discontinuation for every resident that discontinues hospice services. d. Audits will be completed monthly for all residents discontinuing hospice services with results reported to the Quality Assurance Committee. e. DON or Designee responsible for monitoring. Correction date March 5, 2014.	

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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:	F 315		

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F 315	Continued From page 16 9/16/13- "Resident was incontinent of small amount of urine, PVR done, 238 ml present in bladder. No skin issues noted." 9/18/13- "When staff checked residents last PVR was over 200 ml. Put resident on PVR checks every shift until Friday and will address with [physician]. Difficult to tell if resident had just voided or not due to resident does not voice when she needs to go to the bathroom." 9/18/13- "PVR 100. No complaints of pain..." 9/19/13- "Resident PVR for 423. Abdomen soft." 9/19/13- "Abdomen noted to be distended. Had been PVR for 620 ml. Staff waited for an hour and then rechecked to see if she had voided. No void. Abdomen palpated with discomfort noted. Updated [hospice] who stated to attempt to get her up and see if she can void on the toilet. If she does not or voids very little can insert a [urinary catheter] per hospice standing orders. Resident was assisted onto commode. She voided approximately 100 cc. Urinary catheter was inserted for 450 cc of brown, foul smelling, sediment filled urine. At the end of the cathing the urine was a milky color..." During interview on 2/5/14, at 9:55 a.m. clinical manager (CM)-A stated R13 had a urinary catheter placed related to comfort and high PVR's per hospice standing orders. CM-A stated she was unable to provide any documentation of high PVR's or urinary retention except the charting from 9/19/13. CM-A verified R13 had a significant decline in her health condition at that time and	F 315		

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F 315	Continued From page 17 was not taking fluids or eating and had just been treated for a urinary tract infection in August 2013. R13 had been discharged from hospice at the beginning of January 2014 related to weight gain and improvement in her health condition. CM-A verified the facility had not attempted to remove the indwelling urinary catheter even though R13's condition had improved, nor was the current diagnoses provided by the physician of vaginitis with skin breakdown an appropriate diagnoses for ongoing use of a indwelling catheter. Although R13 had an improvement in health status, they had not reassessed R13 indwelling catheter to determine if she had continued ongoing high PVR's or urine retention. The facility did not attempt to remove the urinary catheter in 5 months, since insertion to determine if R13 continued to need a indwelling urinary catheter. A policy on urinary catheter justification was requested but not provided.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	The facility ensures that the resident environment remains as free of accidents hazards as is possible. a. Care plan has been updated to include a fluid impervious clothing protector on chest and lap as well as covered cups when served hot liquids.	

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F 323	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct assessment and implement interventions to prevent further 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 R7 when burns were sustained a second time. In addition, Furthermore, the facility failed to ensure fall interventions were in place for 1 of 3 residents (R45) reviewed for falls. Findings include: R7 sustained second degree burns from spilled hot coffee on 11/23/13, the facility failed to implement interventions to prevent further burns for R7 and on 12/2/13, R7 sustained another second degree burns from spilled hot coffee, resulting in actual harm. R7's significant change Minimum Data Set (MDS) dated 11/18/13, included diagnoses of a stroke and arthritis. The MDS indicated R7 had severe cognitive impairment and required extensive assistance with eating/drinking. The cognitive loss/dementia Care Area Assessment (CAA) dated 11/13/13, indicated R7's cognition varied considerably from being alert and oriented to extremely confused. The ADL (activities of daily living) functional/rehabilitation potential CAA dated 11/13/13, indicated R7 was declining in condition and started end of life hospice care. R7's care plan dated 1/21/14, identified R7 needed assistance with meals and encouragement with fluids. All hot liquids needed to be covered with lids related to resident's history of spilling hot liquids on self.	F 323	b. Residents that were previously using covered cups for hot liquids are now also using fluid impervious clothing protectors to prevent spills from permeating to their skin. c. Coffee and Cocoa machines have been moved into the Dietary department for closer supervision of these hot items. Thermostats on the beverages have been lowered to 140 degrees. Light tan colored cups are being used so residents can see the level of coffee in the cups. Fluid impervious adaptive clothing protectors, covered cups, and spout cups are being used for those residents who have difficulty with fine motor dexterity. Residents are assessed on an on-going basis by RNs, OT, or SLP. Dining Room Committee meets semi-monthly and reviews and addresses any concerns they see in the Dining Room. Facility incident report has been updated to include a revised Fall Scene Investigation with intervention to prevent recurrence. In-service to staff on 3/5/2014 and 3/6/14. d. Dietary monitors temperature of hot beverages daily prior to meals. RN Managers will perform monthly audits of restorative needs/ adaptive equipment use of their residents, completion of incident reports, and	

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F 323	Continued From page 19 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 beverages. R7's Resident Incident Report, dated 11/23/13, indicated R7 had spilled coffee on her lap on 11/22/13, in the facility dining room and sustained 0.5 c.m. (centimeter) blister on her right inner thigh. The blister was intact with no redness. According to the incident report, an ice pack was immediately applied to the burned area. No additional interventions were implemented after the resident burned her thigh. R7's Resident Incident Report, dated 12/2/13, at 3:00 p.m. included R7 was found in her recliner with her coffee cup in her lap. The resident stated, "I'm sorry, I fell asleep," then began crying a few minutes later. Blisters were found on her right inner thigh, measuring 0.7 cm X 1.8 cm, 0.2 cm X 4 cm and 0.5 cm X 2 cm. The blisters were open. An ice pack was applied. Additionally Mepiliex (a soft foam dressing that absorbs wound fluid) was applied to the area. The physician was contacted and ordered Silvadene ointment (a topical ointment used to treat and prevent bacterial infection in second and third degree burns) to be applied to the area daily. Staff were instructed to, "Cover all hot liquids-Required." A progress note from the hospice staff dated 12/3/14, indicated R7 was having pain from the burned area. R7's progress note dated 12/4/13, indicated the blister area to the right inner thigh measured a	F 323	report findings to Quality Assurance committee. Director of Nursing responsible. e. Correction Date 3/5/2014	

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F 323	Continued From page 20 total of 10 cm X 3 cm and there were additional 2 smaller blisters that were intact on the outer edges. The large blister had opened and had beefy red area noted to the wound bed. Although R7 had two separate incidents of second degree burns from coffee, the facility had not assessed her to determine if she could safely handle hot beverages independently at the current temperature. R59 sustained redness to skin from spilling hot chocolate on himself on 10/9/13, the facility did not implement measures to prevent burns for R59 and on 10/10/13, R59 sustained another incident where hot chocolate was spilled which could have caused burns to skin. R59's quarterly MDS dated 1/6/14, included a diagnosis of dementia, severe cognitive impairment, and required supervision and one person physical assistance with eating/drinking. R59's care plan dated 1/6/14, identified cover cups for all fluid especially hot fluids, set up tray and assist with meal as needed. R59's Resident Incident Report dated 10/9/13, at 5:30 p.m. included R59 had sustained a burn from hot chocolate while in the dining room. No interventions were placed to ensure R59 would not spill hot liquids on himself again and suffer additional burns. R59's progress notes dated 10/9/13, indicated R59 dropped his hot chocolate onto his upper thighs. He sustained slight redness to the area with no evidence of blistering. An ice pack was	F 323		

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F 323	Continued From page 21 applied. R59's Resident Incident Report dated 10/10/13, at 5:15 p.m. indicated R59 again spilled hot chocolate onto his lap. An ice pack was placed on the, "burned area of his thighs." His thighs were red but the redness was, "gone by HS (bedtime)." As result of the second incident, staff recommended all liquids should have covers. Although R59 had two separate incidents of spilling hot chocolate, the facility had not assessed him to determine if she could safely handle hot beverages independently. When interviewed on 2/5/14, at 11:45 a.m. the director of nursing (DON) stated she was aware R7 and R59, had all sustained burns from hot liquids. The DON added that R7 and R59 were assessed to require covers on their hot beverage containers, but was not implemented until after the 2nd incidents. Temperatures of the hot beverages were tested with the DM on 2/5/14, at 11:51 a.m. The Cafitesse 3000 automatic coffee/hot liquid dispenser was found in the open main dining room, which served 43 residents of varying cognitive and mobility impairment levels. The DM estimated 40 of the residents were capable of drinking hot beverages independently. The DM checked the temperature of the hot beverages and the coffee was 161 degrees Fahrenheit (F), the decaffeinated coffee was 169 degrees F, hot water was 163 degrees F and hot cocoa was 147 degrees F. A facility policy dated 8/2013 Adaptive Feeding Equipment, identified, "Residents will be provided with adaptive feeding equipment upon	F 323		

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F 323	Continued From page 22 assessment by the licensed nursing and therapy staff." The procedure includes, "Resident with limited and fine motor skills or tremoring of the hands/arms, at risk for spills, will be assessed for the appropriateness of covered cups for liquids to prevent spills..." R45 had sustained five falls while attempting to take herself to the toilet. The facility failed to ensure staff assisted her to the toilet, and used appropriate foot wear as directed by her care plan. R45's admission Minimum data set (MDS) dated 11/28/13, identified the resident had no cognitive impairment, required extensive assistance with toileting, and had a history of falls prior to and since the recent admission to the facility. During observation on 2/4/14 at 9:19 a.m. R45 was observed walking in the hallway wearing a transfer belt being assisted by an [unknown] nursing assistant (NA). The resident was walking quickly and had a slight shuffle when she walked. R45's care plan dated 12/30/13 identified the resident was at high risk for falls related on dependence on staff for transfers and toileting, impaired cognition, medications, and many falls at home. The care plan indicated the resident was independent with bed mobility, transfers and ambulation, locomotion in wheelchair in room and out of room "depending on residents condition," and resident was to wear grippy socks or shoes on at all times. R45's toileting plan included resident was frequently incontinent of urine, with most incontinence seen during the night.	F 323		

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F 323	Continued From page 23 Toileting plan adjusted to include staff assist to toilet on routine night rounds. The care plan instructed staff to assist to the bathroom every two hours, on night rounds, and make sure to wake on 4:00 a.m. rounds and as needed per her request. Upon review of R45's falls on the Resident Incident Report indicated the following: 11/23/13 at 7:20 a.m.- "Resident found sitting on butt in bathroom. Resident stated she was going to bathroom and slowly slipped to floor... had regular socks on feet." The immediate intervention identified was to ensure "grippy socks" were on at night. The incident report indicated the resident had last been toileted during, "last rounds." During interview on 2/5/14, at 5:15 p.m. registered nurse (RN)-B stated R45 was on a toileting program of being toileted every two hours. RN-B stated there was no way to tell according when the resident had last been toileted, however, she had assumed it had been between 5:30 a.m. and 6:00 a.m., as that is when last rounds was, "Usually," completed. 12/20/13 at 2:20 p.m.- "Resident found sitting on her buttocks in bathroom floor and states she was backing up to the toilet and sat down too soon..." The resident was only wearing regular socks at the time. The immediate intervention at that time was to remind resident to ask for assistance if she, "feels she needs it," and to look back at the toilet before sitting down. There	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	02/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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F 323	Continued From page 24 is no indication of when the resident had last been assisted with toileting. During interview on 2/5/14, at 5:15 p.m. RN-B stated R45 was reminded to ask for assistance at that time. RN-B verified there was no indication of when the resident had last been assisted to the bathroom with staff. 12/30/13, at 2:00 p.m.- "Found in bathroom. Sitting on her bottom on the floor in front of toilet in a sitting position... admits to hitting head... wearing socks at time of fall." Immediate intervention at this time was to wear gripper socks or shoes at all times. The incident report indicated, "self toileted at 1:00 p.m." A follow up Resident Progress Note dated 12/30/13, at 3:35 p.m. indicated, "Writer called to resident room approximately 3:15 p.m. with reports resident having emesis. Resident continued to have emesis with dry heaves. Resident noted to have fall approximately 2:00 p.m. where she hit her head on the toilet. Neuros started at 2:00 p.m. and it was noted her systolic blood pressure went from 118 to 160-170's. Also noted temperature went from 97-98.7 in a short amount of time. No injuries noted at time of fall and at 3:15 p.m. resident noted to have swelling to right side of back of head... send to emergency room (ER)..." Follow up Progress Note on 12/30/13 at 6:46 p.m. from the emergency room nurse indicated there were no findings at the ER and resident returned to the facility that evening. During interview on 2/5/14, at 5:15 p.m. RN-B	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	02/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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F 323	Continued From page 25 stated R45 toileted herself and often did not ask for help. RN-B stated R45 should have been assisted by staff with toileting every 2 hours. 1/13/14, at 7:50 a.m.- "Resident alerted staff with call light at 7:50 a.m., when writer entered room resident was sitting on floor next to bed with walker in front of her, reported she had been tangled up in her bedding... assisted to bathroom." Resident had bare feet at the time of the fall. The incident report indicated the resident had last been toileted at 3:00 a.m. During interview on 2/5/14, at 5:15 p.m. RN-B stated R45 had been care planned to be toileted every two hours and have gripper socks on at all times. RN-B verified the report indicated R45 had not been toileted since 3:00 a.m., 4 hours and 50 minutes before the fall, and also the resident did not have any gripper socks on as care planned. RN-B stated she had no further information regarding why this had not been done. 1/26/14 at 7:20 a.m.- "Found sitting on floor in room between bathroom and hallway door...slipped onto bottom... wearing regular socks at the time of the fall." The incident report indicated the resident was last toileted and repositioned "per self" and "needed gripper socks on at all times or shoes." During interview on 2/5/14, at 5:15 p.m. RN-B stated she was unsure why the resident had not been toileted or did not have gripper socks on at the time of the fall. RN-B stated R45 had been	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	02/05/2014

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F 323	Continued From page 26 assessed as needing toileting with staff assistance every two hours, however, she believed that staff may be just checking on the resident at the beginning of their shift to see if the resident is strong enough to toilet herself that day. During interview on 2/4/14, at 9:13 a.m. nursing assistant (NA)-B stated R45 can be independent with toileting and staff will ask her if she feels weak or not that day. If she is weak staff will assist her with toileting. During interview on 2/4/14 at 9:43 a.m. NA-A stated staff will check with resident about every two hours to see how she feels in regards to toileting herself. Although all of R45's falls were related to self toileting, the facility failed to ensure the fall interventions which were put in place were being followed or appropriate. A facility fall policy was requested but not provided.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 356	a., b., c., A new Daily Staffing Totals form has been developed. It is the responsibility of the Staffing Coordinator/ Health Unit Coordinator to complete and post this form including Census.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	02/05/2014

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F 356	Continued From page 27 resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility failed to ensure the nurse staffing information posting was kept current all days of the week. This had the potential to affect 53 of 53 residents, family members and any visitors who may choose to view this information. Findings include: During observation of the initial tour on, Sunday, 2/2/14, at 9:30 a.m., a nurse staff posting form	F 356	d. Form completion will be monitored weekly x one month or until sustained compliance is achieved as evidenced by 7 consecutive days of completion, then quarterly through 2014. e. Monitoring will be the responsibility of the Staffing Coordinator or designee. Corrected 2/7/2014	

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F 356	Continued From page 28 was hanging in the window of the primary nursing station. The nursing posting visible to residents and visitors were dated 1/30/14 to 2/1/14. On the back of the posting were the nursing hours for 2/2/13 to 2/5/14 but these hours were not visible to residents or visitors. When interviewed on 2/4/14, at 11:00 a.m. the facility scheduler (FS)-A stated she completes the nurse staffing information posting six days at a time. She fills in the scheduled hours and the actual hours of nursing staff. She is responsible to ensure the posting was visible for the current day during week days. No staff was assigned to do this on the weekends. When interviewed on 2/4/13, at 2:10 p.m. the director of nursing (DON) verified these findings. The assistant director of nursing (ADON) reported on 2/5/13, at 8:20 a.m. that she was unable to find any policy that addressed nursing posting.	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS - 2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN 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.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Benedictine Living Community of New London was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO:

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
444 CEDAR STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

POC OK
3-28-14

RECEIVED
MAR 28 2014
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

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

Administrator — 3/28/14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/04/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1	K 000		

By e-mail to:
Marian.Whitney@state.mn.us

3-17-14 DC; 3-5-14 EXIT:

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Benedictine Living Community of New London is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1964 and was determined to be of Type II(000) construction. In 1993 and addition was added to the south of the Service Wing that was determined to be of Type II(000) construction. In 1996 and addition was added to the north of the Service Wing that was determined to be of Type II(000) construction. In 1999 and addition was added to the south of the 1993 addition that was determined to be of Type II(000) construction. Because the original building and the 3 additions are of the same type construction the facility was surveyed as one building.

The building is fully protected by a fire sprinkler system. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for

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MAR 10 2014
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/04/2014

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K 000	Continued From page 2 automatic fire department notification. The facility has a licensed capacity of 62 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect all residents, visitors and staff of the facility. Findings include:	K 056	Grace Living Community of Glen Oaks' automatic sprinkler system has 2 different types of sprinkler heads that meet the requirement under code standard NFPA 101. 2 of each kind of sprinkler heads will be kept by the maintenance department on an on-going basis. Extra sprinkler heads have been ordered for both styles. Correction Date: 3/21/14 The sprinkler gauges located on the main fire sprinkler have been replaced. Maintenance Director will monitor for compliance and is responsible for re-ordering as necessary Correction date 3/7/2014	

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	245360	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/04/2014**

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K 056	Continued From page 3 On facility tour between 10:00 AM to 1:00 PM on 02/04/2014, observations reveled the following deficient conditions were found affecting the facility's fire sprinkler system: 1. the spare sprinkler head box was not equipped with at least 2 of every type and style of sprinkler heads that are being used in the facility. The observed missing spare sprinkler heads were the same type as the ones located in the main sprinkler riser and spare sprinkler head box is located. 2. The sprinkler gauges located on the main fire sprinkler riser have not been tested/replaced since 2008. These deficient practices were verified by the Maintenance Supervisor (BN).	K 056		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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

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

and the Time Period For Correction.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00314	A. BUILDING: _____ B. WING _____	02/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On February 2, 3, 4, and 5th, 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	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.	