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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UQR2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00861

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245236**
2.STATE VENDOR OR MEDICAID NO.
(L2) **819240500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE HEALTH CENTER**
(L4) **935 KENWOOD AVENUE**
(L5) **DULUTH, MN** (L6) **55811**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/27/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **96** (L18)
13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(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 :
Yvonne Switajewski, HFE NEII 08/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/19/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/17/1980
(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
07/12/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245236

September 19, 2016

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

Dear Mr. Pattock:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 23, 2016 the above facility is certified for:

96 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 96 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 12, 2016

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

RE: Project Number S5236027

Dear Mr. Pattock:

On June 6, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 26, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On July 26, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 12, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 26, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 5, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 26, 2016, effective July 23, 2016 and therefore remedies outlined in our letter to you dated June 6, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245236 Y1	A. Building B. Wing Y2	7/26/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER	935 KENWOOD AVENUE DULUTH, MN 55811

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0226	Correction	ID Prefix F0241	Correction	ID Prefix F0279	Correction
Reg. # 483.13(c)	Completed	Reg. # 483.15(a)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed
LSC		LSC	07/05/2016	LSC	07/05/2016
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0311	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(a)(2)	Completed
LSC	07/05/2016	LSC	07/05/2016	LSC	07/05/2016
ID Prefix F0334	Correction	ID Prefix F0441	Correction	ID Prefix	Correction
Reg. # 483.25(n)	Completed	Reg. # 483.65	Completed	Reg. #	Completed
LSC	07/05/2016	LSC	07/05/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TA/mm	08/12/2016	18619	07/12/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/26/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245236	A. Building 01 - MAIN BUILDING 01 B. Wing	7/12/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER	935 KENWOOD AVENUE DULUTH, MN 55811

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0027	Correction Completed 05/27/2016	ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 06/14/2016	ID Prefix Reg. # NFPA 101 LSC K0104	Correction Completed 06/28/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) TL/mm	DATE 08/12/2016	SIGNATURE OF SURVEYOR 27200	DATE 07/12/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/25/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UQR2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00861

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245236**
2.STATE VENDOR OR MEDICAID NO.
(L2) **819240500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE HEALTH CENTER**
(L4) **935 KENWOOD AVENUE**
(L5) **DULUTH, MN** (L6) **55811**

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)

6. DATE OF SURVEY **05/26/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **96** (L18)
13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(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 :
Debra Vincent, HFE NEII 06/23/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/11/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **11/17/1980** (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

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

CCN: 24 5236

On May 26, 2016, a standard survey was completed at the facility 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 the facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) , whereby corrections are required. In addition, at the time of the May 26, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5236039 and H5236040 that were found to be unsubstantiated. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 0434

June 6, 2016

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

RE: Project Number S5236027, H5236039 and H5236040

Dear Mr. Pattock:

On May 26, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) , as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the May 26, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5236039 and H5236040 that were found to be unsubstantiated.

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

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 July 5, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected

by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

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

- Include signature of provider and date.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 26, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 26, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245236	A. BUILDING _____ B. WING _____	05/26/2016

RECEIVED
JUN 22 2016
Minnesota Department of Health
Bemidji

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER	935 KENWOOD AVENUE DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 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 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 standard recertification survey was completed on May 26, 2016 and complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaint H5236039 and H5236040 were not substantiated during this survey.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT 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 interview and document review the facility failed to implement their Vulnerable Adult Protection Plan policy and procedure related to the completion of background screenings for 5 of 6 culinary employees (CE-A, CE-B, CE-D, CE-F) reviewed from the dietary department.	F 226	F226 All contracted culinary employees (CCE) who have direct care with the residents have had their personal files reviewed to assure background studies were completed upon hire. All CCE who were lacking background studies have been submitted. All returned background studies will be reviewed by the culinary supervisor and a copy sent to the administrator. If the background study indicates the individual is not able to work without supervision, the individual will not be able to work directly with the residents until the background check has been cleared.	APPROVED 6/23/16 LB

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: B - Pattee | TITLE: Administrator | (X6) DATE: 6-17-16

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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	245236	A. BUILDING _____ B. WING _____	05/26/2016

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F 226	Continued From page 1 Findings include: The facility policy Vulnerable Adult Protection Plan revised on 5/16, indicated the policy was developed to protect vulnerable adults who live at the facility to ensure all residents are free from verbal, sexual, physical, spiritual and mental abuse, financial exploitation, corporal punishment and involuntary seclusion. A key component identified was screening of employees and volunteers. The policy indicated before new employees or volunteers are permitted to work with residents, a criminal background check would be conducted and references provided from the prospective employee or volunteer must be checked. The policy indicated employees, temporary agency staff, residents, families, volunteers and consultants would have VA training at orientation and annually. On 5/23/16, at approximatly 3:00 p.m. an initial tour was completed in the dietary department (kitchen, dishwashing room and storage area) which was at the end of a hallway where residents reside. The dietary department had a gate across the door with a latch to prevent wandering residents from entering into the kitchen. On 5/25/16 at 11:41 a.m. the RD stated there were 37 culinary employees who worked at the facility. The RD explained the kitchen was actually owned by a different entity, (even if it was in the same building) and the care facility contracted with the kitchen. The RD stated the	F 226	All CCE who have direct care with the residents have been trained on vulnerable adult reporting. A new "tool" kit with VA reporting and other VA information has been developed and available for staff to review or refer to. All CCE who have direct care with the residents will do VA training prior to hire by doing an online VA training course or attend an in person orientation session that covers VA reporting. All CCE who have direct care with the residents will be trained on VA an annual basis. Annual all employee audits will be conducted. The facility Vulnerable Adult policy has been reviewed and remains appropriate.	

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

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F 226	Continued From page 2 kitchen staff provided all the meals and snacks, delivered meal carts to the care center, and served breakfast in the care center from a steam table. The RD was interviewed about new employee orientation and who was responsible to ensure the employees received vulnerable adult (VA) training according to the facility VA protection plan. The RD stated there had been no vulnerable adult training in orientation or no annual VA training provided to the culinary employees since she started working there in 12/2011. The RD was asked about background screening for new employees and the RD stated the background studies were not being completed on new employees in that department. CE-A was hired on 5/26/15-no background screening on file CE-B was hired on 12/3/15-no background screening on file CE-C was hired on 2/8/16-no background screening on file CE-D was hired on 4/27/11-no background screening on file CE-E was hired on 5/6/13-background screening completed on 10/7/13 (5 months after hire date) CE-F was hired on 6/17/10-no background screening on file On 5/26/16 at 11:00 a.m. the RD verified there was only one background study completed on the six employees reviewed. RD stated the culinary staff should probably have background studies completed because they do have contact with residents when serving breakfast and are in the nursing home delivering trays, and stocking the refrigerators and cupboards.	F 226	The contracted organization has committed to sharing copies of background studies and notice of VA training has been completed of new hires to the facility prior to on floor orientation. The Administrator or designee will audit all contracted culinary employees monthly for three months then quarterly until the quality assurance (QA) deems 100% compliance. The administrator is responsible. Date of compliance July 5, 2016	

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F 226	Continued From page 3 On 5/25/16 2:55 p.m. the administrator stated the culinary staff were not employed by the facility but were contracted. The administrator stated it should not be the facility's responsibility to ensure all contracted staff have background studies or VA training. On 5/26/16 at 9:43 a.m. the social worker (SW) stated all employees who have contact with the residents should have the VA training and background studies completed. The SW stated the staff who work in the kitchen should have had the background studies completed. On 05/26/16 at 11:19 a.m. the director of nursing and the administrator both confirmed all other staff who worked at the facility and the volunteers who came to the facility were expected to have background studies completed and the culinary employees should as well. The administrator again stated the facility should not be responsible to complete them but rather the contractor who owned the kitchen should. The agreement between the facility and owner of the dietary department, dated 7/31/91, indicated the food service responsibility was to provide hygienic dietetic services that met the daily needs of residents/employ sufficient supportive personnel competent to carry out the function of dietetic service. The agreement indicated food service personnel were on duty daily over a period of 12 or more hours a day and they were to ensure that at least three resident meals were served daily. The agreement also indicated the	F 226		

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F 226	Continued From page 4 facility retained ultimate responsibility for the services rendered by the food service.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience during 1 of 1 evening meal observation in the Green dining room on third floor which affected 4 residents (R51, R186, R210, R210) with the potential to affect all 10 residents eating in the green dining room. Findings include: R51's quarterly Minimum Data Set (MDS) dated 2/22/16, indicated R51 had a diagnosis of dementia, anxiety and depression, had severe cognitive impairment and required total staff assistance to eat. R186's quarterly MDS dated 4/14/16, indicated R186 had a diagnosis of Alzheimer's dementia, had severe cognitive impairment and required total staff assistance to eat. R210's quarterly MDS dated 4/30/16, indicated R210 had a diagnosis of aphasia, hemiparesis, and heart disease, had severe cognitive impairment and required total staff assistance to	F 241	F241 R51, R186, and R210 all have been relocated to a larger dining room. R219 has expired. All other residents who ate in the Green dining room have also been relocated to a larger dining room where there is more supervision and more staff available to assist those residents who need feeding assistance. All staff has been reeducated on the proper feeding techniques to include sitting down in a chair next to the residents while assisting them during meal times. The Assistance with meals policy was reviewed and remains appropriate. The DON or designee will conduct 3 audits weekly to assure compliance. Audits will include all 3 meals. Any discrepancies will be reviewed with the Administrator and shared with	

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F 241	Continued From page 5 eat. R219's admission MDS dated 4/22/16, indicated R51 had a diagnosis of dementia, severe cognitive impairment and required total staff assistance to eat. On 5/23/16, at 5:50 p.m. 10 residents were observed seated in the third floor, Green dining room. One male resident was seated at a table alone looking out the window and eating independently. There were three other residents who were also eating independently. There were four residents seated at a square table who had been served their meals, but were not observed to pick up their utensils and take a bite. The meal consisted of chile, corn muffin, salad and beverages. There were two empty chairs between the four residents. -At 6:02 p.m. licensed practical nurse (LPN)-B was observed seated in one of the chairs while assisting R51 and R186 with their evening meal. The residents were accepting of each bite of food. At this time, the surveyor exited the dining room. -Upon return to the green dining room at 6:13 p.m. nursing assistant (NA)-B was observed to be all alone in the dining room. NA-B was observed walking around the square table and going between the residents giving them bites of food. -At 6:15 p.m. NA-B gave R186 a bite of pudding, which R186 accepted without problems, at the same time she was verbally encouraging R51 to pick up a utensil and take a bite of corn muffin. R51 did not respond. NA-B proceeded to walk around the table and physically assisted R51 with a bite of muffin dipped in chili. NA-B walked over to R210 and gave that resident a bite, then walked around the table and gave R186 a bite.	F 241	QA. Audits will continue until QA deems 100% compliance. The Director of Nursing (DON) or designee is responsible. Date of compliance July 5, 2016	

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F 241	Continued From page 6 NA-C entered the dining room, stood up behind R210 and physically assisted R210 with eating while standing behind or beside him and next to an empty chair. NA-B used hand sanitizer and stated to NA-C if they had rubber gloves on they would not have to keep using sanitizer every time they change residents. -At approximately 6:22 p.m. LPN-B was back in the dining room, sat down at a different table next to a resident to encourage that resident to eat. -At 6:24 p.m. NA-B handed R51 a beverage glass and proceeded to stand behind R51, next to an empty chair. NA-C and LPN-B exited the dining room. NA-B gave R51 a few more bites, walked behind R210 and gave R210 a bite of food with verbal cues to swallow it all. -At 6:30 p.m. NA-B gave R51 another bite of food, R186 was not eating rather, fiddling with the tray on the table. R219 was observed to have two bites offered to her but did not swallow them and was not offered anything else. -At 6:37 p.m. NA-C was the only staff person in the green dining room and was carrying the dirty dishes to the carts. NA-C stopped to give R210 a bite and proceeded to walk over to a different table and sat down next to another resident. LPN-B returned to the dining room for a very short time and was called to another room, NA-B returned, continued to go from resident to resident assisting them to eat until most of the food was gone. NA-B took R51 and R186's meal tray and put them on the cart. -At 6:45 p.m. NA-C stopped to give R210 a bite of ice cream, NA-C was observed to keep the small container in one hand while walking around the dining room cleaning off some of the other tables and would return to R210 and give the resident a bite of ice cream. -At 6:47 p.m. NA-C (continued to walk around the	F 241		

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F 241	Continued From page 7 dining room) was heard saying R210 had the last bite of ice cream and was observed giving R210 a glass of water with a lid on it. R210 did not attempt to drink the water. On 5/25/16, at 12:40 p.m. the director of nursing (DON) was interviewed regarding the dining room observation and verified it was not a dignified dining experience. The DON stated staff should have been seated when assisting residents to eat and added there should have been more staff assisting with the meal and to provide dignity with dining. On 5/26/16 at 2:28 p.m. NA-B verified there were 10 residents in the dining room on the evening of 5/23/16, and stated there were only two staff members assisting with the evening meal in the green dining room and there are at least four residents who are total assist with feeding. NA-B stated there was not time to sit down with the residents and assist them, they have to keep moving. The Assistance with Meals policy dated September 2013, noted for residents requiring full assistance with meals and cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: 1, not standing over residents while assisting them with meals. 2. Keeping interactions with other staff to a minimum while assisting residents with meals 3. Avoiding the use of labels when referring to residents (e.g. " feeders ")	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		

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F 279	Continued From page 8 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 interview and document review, the facility failed to develop the care plan related to psychotropic medication use, it's related side effects and/or interventions for 1 of 5 residents (R145) reviewed for unnecessary medications whose psychotropic care plan was not developed. Findings include: R145's admission Minimum Data Set (MDS) dated 3/22/16 indicated R145 had moderate cognitive impairment and diagnoses which included dementia with behavioral disturbance,	F 279	F279 R145's care plan has been comprehensively developed to include side effect monitoring and interventions for psychotropic medication use. Comprehensive care plans were reviewed for 18 residents 3 from each hall to assure comprehensive care plans were developed. The DON or designee will continue to audit new admissions to verify comprehensive care plans have been developed. Audits will continue until the QA deems 100% compliance. The Director of Nursing (DON) or designee is responsible. Date certain July 5, 2016	

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F 279	Continued From page 9 seizure disorder, anxiety, and depression. The MDS also indicated R145 received antipsychotic and antidepressant medications daily. R145's Psychotropic Medication Use Care Area Assessment (CAA) dated 3/25/16, indicated R145 was admitted with diagnoses of anxiety and depression and was currently receiving mirtazapine daily at bedtime, risperidone three times a day and PRN, as well as Venlafaxine. The CAA also indicated R145 had weepiness at times noted due to change in environment and looking for her family and would proceed to care plan for use of psychotropic medications and for changes in mood/behavior. Staff was to report any drug side effects or changes in mood/behavior to the physician. R145's Current Orders included the following physician orders: mirtazapine (antidepressant) 15 milligrams (mg) once and evening started on 3/15/16 Venlafaxine (antidepressant)150 mg once a day started on 3/15/16 risperidone (antipsychotic) 0.25 mg three times a day and every 4 hours as needed (PRN) with a maximum of 3 PRN doses started on 3/15/16 R145's undated current Care Plan did not address the use of these psychotropic medications On 5/26/16, at 10:54 a.m. clinical manager (CM)-A confirmed R145's care plan lacked indication of psychotropic medication use, potential side effects and/or interventions related to it's use.	F 279		

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F 279	Continued From page 10 On 5/26/16, at 3:00 p.m. the director of nursing (DON) confirmed R145's care plan should have been developed to included interventions for the use of psychotropic medications. The Comprehensive Care Plans policy dated September 2010, indicated an individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs was developed for each resident. The policy also indicated areas of concern that were triggered during the resident assessment were evaluated using specific assessment tools (including Care Area Assessments) before interventions were added to the care plan.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral hygiene was provided as directed by the care plan for 1 of 4 residents (R145) who required assistance with oral hygiene. Findings include:	F 282	F282 R145's care plan has been reviewed and remains appropriate. The nursing assistant responsible for not brushing R145's lower teeth has been re-educated. All other	

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F 282	Continued From page 11 R145's Care Plan dated 3/25/16, indicated R145 required staff assistance with completing oral cares due to impaired mobility and cognitive deficit. The plan indicated R145 had full upper dentures which was loose and some natural teeth on lower and directed staff to assist with set up for oral cares/teeth brushing. On 5/25/16, at 7:44 a.m. nursing assistant (NA)-D was observed to enter R145's room, greet her, retrieve a basin with supplies and brought to the bathroom. NA-D washed her hands and filled basin with water. NA-D assisted R145 to donned socks and shoes, sit on edge of bed and placed a walker in front of R145. NA-D assisted R145 to ambulate to the bathroom and sit on toilet. Once on the toilet, R145 voided followed by NA-D providing partial bath assistance. After the cares, NA-D washed her hands, donned clean gloves, rinsed out R145's upper denture plate, applied denture adhesive and assisted R145 to place the denture in her mouth without offering R145 the opportunity to rinse her mouth or brush her lower natural teeth. NA-D completed R145's dressing, placed the walker in front of R145, assisted to stand, completed peri cares, removed her gloves, washed her hands and proceeded to brush R145's hair and assisted her to put on her glasses. Following the completion of these cares, R145 ambulated independently to the dining room. R145 remained seated at a table in the dining area throughout the breakfast meal. -At 9:14, a.m. activity aide (AA)-A assisted R145 to stand up from her seat at the dining room table, ambulate to common area sitting area and sit in a recliner with her feet elevated and a	F 282	staff has received the oral care policy which requires a signature that they have reviewed and understand the policy. A list of resident's who need assist with oral care has been developed. 3 Audits a week will be completed by the DON or designee on both days and pm's to assure oral care is being provided per care plan. Any discrepancies will be turned into the nurse mangers for follow up. Audits will continue until QA deems 100% compliance. The Director of Nursing (DON) or designee is responsible Date of compliance July 5, 2016	

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F 282	Continued From page 12 blanket on her lap. Oral cares were not offered. On 5/25/16, at 1:08 p.m. NA-D confirmed she had not offered R145 the opportunity to rinse her mouth or brush her lower teeth during morning cares or after breakfast and stated she should have done so. On 5/26/16, at 10:54 a.m. Clinical Manager (CM)-A confirmed oral cares should have been provided with morning cares as directed by the care plan. On 5/26/16, at 3:00 p.m. the director of nursing (DON) confirmed oral cares should have been provided as directed by care plan. The Using the Care Plan policy dated August 2006, indicated the care plan would be used in developing the resident's daily care routines and would be available to staff personnel who had responsibility for providing care or services to the resident.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure coordination of care was provided for 1 of 1 (R101) resident who recieved hospice services. Findings include: R101's quarterly Minimum Data Set (MDS) dated 5/3/16, indicated R101 was diagnosed with dementia and had a condition that may result in life expectancy of less than six months. The MDS identified R101 as being totally dependent on staff for all activities of daily living. R101's current physician orders included an order dated 11/8/15, admit to hospice election program and to Fax medication refill request to hospice requesting all hospice covered medications needed to be refilled on Mondays. R101's care plan dated 12/22/15, indicated R101 was receiving hospice care with a goal to maintain comfort and the facility would refer care issues/needs and medication to hospice. On 5/26/16, at approximately 8:30 a.m. the director of nursing stated the hospice care plan and visit notes could all be found in the hospice section of the R101's paper medical record. The DON stated the hospice staff did not document in the facility electronic record. However, the only care plan included in the medical record was an initial plan dated 11/8/15, which indicated R101's terminal diagnosis was Alzheimer's dementia and a hospice nurse was to visit twice a week, the	F 309	F309 R101's care plan has been updated to reflect the coordination of care between Hospice and the facility. A list of all residents receiving hospice services has been developed. All hospice care plans have been reviewed/revised as needed to include the coordination of care between the hospice team and the facility staff. A meeting with the hospice personal and the nurse managers has been set up to discuss the components necessary to assure coordination of care is in place. DON or designee will conduct 1 audit per week to assure care plans	

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F 309	Continued From page 14 social worker as needed and and pet volunteer would visit. R101's medical record revealed the following: -On 5/11/16, the nurse noted care conference today. No changes to care plan. The note indicated a skilled nurse would visit weekly and a social worker would visit as needed. -The hospice social worker also noted on 5/11/16, met for care conference with nursing home team. No needs identified, no family present, social worker to be available as needed. -A skilled nurse visit was completed on 5/18/16, with no concerns noted. -Skilled nurse visit on 5/25/16, indicated R101 was in bed, no signs or symptoms of pain, last bowel movement today, vital signs stable, very pleasant, yawns often during visit, lungs clear and no changes to the care plan. Included in the hospice documentation record was an entry from the occupational therapist (OT) dated 4/21/16, indicating OT received orders for a safety assessment due to patient becoming more difficult to transfer. On 5/5/16, the OT documented R101 was evaluated during transfer and noted patient to continue with heavy assist of two staff for all transfers. However, there was no care plan in the record to direct staff how to assist R101 with transfers. R101's mobility care plan dated 6/5/12, indicated R101 was moderately independent with transfers with room set up. The documentation record indicated pet therapy was completed with a volunteer on 12/17/15, 12/3/15, and 2/11/16. However there was no care plan identifying how often R101 was to receive pet therapy or if the volunteer was to continue	F 309	reflect the residents current hospice needs. All nurse managers have been trained on the Hospice criteria and the importance of coordination of care. Audits will continue until the QA deems 100% compliance. The Director of Nursing (DON) or designee is responsible Date of compliance July 5, 2016	

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

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F 309	Continued From page 15 with that therapy. On 5/25/16, at 8:30 a.m. a nursing assistant (NA) - B was observed to complete a bed bath and totally assist R101 with dressing. R101 was transferred to the wheelchair and then wheeled into the dining room for breakfast where she was observed to be assisted with her meal. R101 was observed to be pleasant with no signs of pain or discomfort. NA-B was interviewed about hospice services at that time and stated she thought a HHA came to see R101 but was not sure when or what she did. The hospice nurse was not able to be reached for comment. The facility Hospice Program policy revised January 2014, indicated when a resident participated in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family would be developed and would include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the patient's current status.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 311		

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F 311	Continued From page 16 review, the facility failed to ensure oral hygiene was provided for 1 of 4 residents (R145) who required assistance with oral hygiene. Findings include: R145's admission Minimum Data Set (MDS) dated 3/22/16 indicated R145 had moderate cognitive impairment and diagnoses which included dementia with behavioral disturbance, seizure disorder, anxiety, difficulty walking and depression. The MDS also indicated R145 required extensive assist of one for bed mobility, transfer, dressing, toilet use, and personal hygiene and required limited assist of one for ambulation. R145's Dental Care Care Area Assessment (CAA) dated 3/25/16, indicated R145 had an upper denture plate which was loose on assessment and had some natural teeth in her lower L gum line and none remaining on the lower R gum. The CAA also indicated R145 was extensive assist of one for oral cares. R145's Care Plan dated 3/25/16, indicated R145 was unable to complete bathing, dressing and grooming independently related to her need for assistance with all mobility and impaired cognition related to dementia. The plan indicated R145 had full upper dentures which was loose and some natural teeth on lower and directed staff to assist with set up for oral cares/teeth brushing. The plan also indicated R145 required staff assist with completion of oral cares.	F 311	F311 R145's care plan has been reviewed and remains appropriate. The nursing assistant responsible for not brushing R145's lower teeth has been re-educated. All other staff has received the oral care policy which requires a signature that they have reviewed and understand the policy. A list of resident's who need assist with oral care has been developed. DON or designee will conduct 3 audits a week on both day and evening shift to assure oral care is being provided per care plan. Any discrepancies will be turned into the nurse mangers for follow up. Audits will continue until QA deems 100% compliance. The Director of Nursing (DON) or designee is responsible Date of compliance is July 5, 2016	

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F 311	Continued From page 17 On 5/25/16, at 7:44 a.m. nursing assistant (NA)-D was observed to enter R145's room, greeted R145, retrieved a basin with supplies, washed her hands and filled basin with water. NA-D assisted R145 to dress lower body and proceeded to assist R145 to ambulate to the bathroom. NA-D assisted R145 to remove gown and gave R145 a wet washcloth to wash her face and upper body. NA-D washed her hands, donned clean gloves and rinsed out R145's upper denture plate, applied denture adhesive and assisted R145 to place denture in her mouth without first offering R145 the opportunity to rinse her mouth or brush her lower natural teeth. NA-D assisted R145 to finish cares and dressing, removed and discarded her gloves. NA-D brushed R145's hair and assisted her to put on her glasses. Upon completion of the morning cares, R145 ambulated independently to the dining room. R145 remained seated at a table in the dining area throughout breakfast meal. --At 9:14, a.m. activity aide (AA)-A assisted R145 to ambulate to the common area sitting area and sit in a recliner with her feet elevated and a blanket on her lap. Oral cares were not offered. On 5/25/16, at 1:08 p.m. NA-D confirmed she had not offered R145 the opportunity to rinse her mouth or brush her lower teeth during morning cares or after breakfast and should have done so. On 5/26/16, at 10:54 a.m. Clinical Manager (CM)-A confirmed oral cares should have been provided with a.m. cares as directed by the care plan.	F 311		

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F 311	Continued From page 18 On 5/26/16, at 3:00 p.m. the director of nursing (DON) confirmed oral cares should have been provided as directed by care plan. The Teeth Brushing policy dated October 2010, indicated the purpose of the procedure were to clean and freshen the resident's mouth, to prevent infections of the mouth, to maintain the teeth and gums in a health condition, to stimulate the gums and to remove food particles from between the teeth. The policy directed a resident should be assisted with brushing his or her teeth based on his or her individual needs.	F 311		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal	F 334	F334 R219 was offered the pneumococcal vaccination on 05/30/2016, however due to declining health R219 declined the vaccination.	

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F 334	Continued From page 19 representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or	F 334	Lists of residents who have been admitted in the last 3 months have been reviewed to determine if pneumococcal and influenza vaccinations were offered and or refusals were documented. Those residents identified as not being in compliance will be provided the information on the vaccines, offered the vaccinations and documented in the residents medical record. DON or designee will conduct monthly audits on all new admissions to assure immunizations were offered and/or declined and documented in the residents' medical record per facility policy. Audits will continue until QA determines 100% compliance. The Director of Nursing (DON) or designee will be responsible. Date of compliance is July, 5 2016	

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F 334	Continued From page 20 the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a pneumococcal immunization was administered or refusal or contraindication was documented for 1 of 5 resident (R219) reviewed for immunizations. Findings include: The facility's Pneumococcal Vaccination policy dated 03/09, indicated newly admitted residents' should receive the pneumococcal vaccination if the resident had received the vaccine greater than or equal to 5 years previously and was less than 65 years old at the time of vaccination. R219's Resident Face Sheet indicated R219 had diagnoses which included acute kidney failure, encephalopathy (any diffuse disease of the brain that alters brain function or structure) anemia (A condition in which the blood doesn't have enough healthy red blood cells), and dementia. R219's admission Minimum Data Set (MDS) dated 4/22/16, indicated R219's pneumococcal vaccination was not up to date. The MDS did not indicate a reason the vaccination was not received and the fields of medical contraindication, offered and declined, and not	F 334		

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F 334	Continued From page 21 offered were blank. R219's medical record lacked documentation the pneumococcal vaccination had been received, was contraindicated, or refused. R219's Facility Standing Order dated 5/9/16 directed staff to administer the pneumococcal vaccine unless contraindicated. On 5/26/16, at 11:51 a.m. licensed practical nurse (LPN)-D, who was the facility infection control nurse, indicated R219 had received the pneumococcal vaccination on 7/12/11, at the age of 64, according to the Minnesota Immunization Information Connection (state system that stores electronic immunization records). LPN-D stated R219 should have been offered an additional pneumococcal vaccination upon admission to the facility and confirmed the record lacked documentation of administration, refusal or contraindication of the vaccination. On 5/26/16, at 3:12 p.m. director of nursing (DON) confirmed R219 should have received a pneumococcal vaccination or documentation of refusal or contraindication should have been documented as directed by facility policy.	F 334		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	F441 R69 and R71's care plans have been reviewed and remain appropriate. Nursing assistant (NA)-A has been re-educated regarding proper glove use and hand washing per facility policy. All other direct care staff	

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F 441	Continued From page 22 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper hand washing was performed during the provision of cares for 2 of 2 residents (R69, R71) observed during the provision of cares.	F 441	have been re-educated on the Hand washing/Hand hygiene policy. A hand washing device was purchased to demonstrate effective hand washing techniques. The machine has the capability of showing staff the areas they missed by illuminating those areas. This devise will be used randomly to assure compliance is achieved. A list of residents who need assist with hygiene has been developed. The DON or designee will conduct 3 audits weekly for 3 months. Results will be presented to QA. Audits will be conducted until the QA determines 100% compliance. The DON or designee is responsible. Date of compliance is July 5, 2016	

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F 441	Continued From page 23 Findings include: R69's quarterly Minimum Data Set (MDS) dated 4/11/16, indicated R69 was diagnosed with dementia, had severe cognitive impairment and required extensive assistance for bed mobility, transferring and personal hygiene. R69's Care Plan dated 4/16/16, indicated R69 was incontinent of bladder and bowel, required extensive assist for mobility, required staff assistance for transferring on and off the toilet and incontinence care. On 5/25/16, at 7:45 a.m. R69 was observed in bed. Nursing assistant (NA)-A was observed to donne gloves and assist R69 with personal cares. R69's brief was removed which R69 was noted to have been incontinent of bladder and bowel. NA-A provided perineal cares using disposable wipes. After the completion of perineal cares, NA-A was not observed to remove her gloves and wash her hands. With the same gloved hands, NA-A picked up a tube of barrier cream, applied a quarter size amount to gloved hand, applied the cream to R69's coccyx area, applied a clean incontinent brief under R69's buttocks and fastened. NA-A removed the gloves, waved her hands in the air and stated her hands get sweaty. NA-A was not observed to wash her hands. NA-A assisted R69 to a sitting position and adjusted and R69's shirt, assisted R69 to transfer into the wheelchair, brushed R69's hair and shaved R69's face using an electric razor. During the provision of cares, NA-A was not observed wash her hands during or after cares. At 8:12 a.m. NA-A stated she should have	F 441		

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F 441	Continued From page 24 removed her gloves and washed her hands and regloved prior to applying the barrier cream to R69's coccyx area. NA-A stated she has had training in handwashing and perineal cares. At 9:48 a.m. registered nurse (RN)-A verified NA-A was expected to wash her hands and change gloves during personal cares and applying creams, and after removing gloves. At 1:48 p.m. the director of nursing (DON) stated she would expect staff to wash their hands between perineal cares and the provision of applying creams and further cares. The facility policy Perineal Care dated 10/2010, indicated staff should wash hands or use hand sanitizer after removing soiled gloves. Then put on clean gloves to put on clean pad and or clothing. The Handwashing/Hand Hygiene policy dated 8/2014, directed staff to wash their hands after providing personal cares involving contact with bodily fluids and before and after direct contact with residents. R71's quarterly MDS dated 4/1/16, included diagnosis of Alzheimer's disease and identified R71 as having a severe cognitive impairment, memory problems and totally dependent on staff for all activities of daily living. R71's Care Plan edited on 1/11/16, indicated R71 was incontinent of bladder but not bowel, required staff assist for transferring on and off the toilet and incontinence care. The POC indicated R71	F 441		

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F 441	Continued From page 25 required minimal to extensive assist for all mobility and directed staff to transfer with EZ stand for all transfers. The plan also identified R71 as having impaired vision and very hard of hearing. On 5/25/16, at 7:14 a.m. R71 was observed sitting in a wheelchair in the hallway wheeling self short short distances. -At 8:16 a.m. NA-A was observed to wheel R71 into R71's room and into the bathroom. NA-A assisted R71 to transfer via a mechanical stand up lift (EZ stand) to the toilet. -At 8:31 a.m. NA-A asked R71 if she was done and then stated R71 had a large bowel movement. NA-A washed her hands and applied gloves, washed R71's bottom and completed incontinence care. R71's brief and pants were pulled up. With the same gloved hands, NA-A transferred R71 back into the wheelchair via the EZ stand lift and wheeled into his bedroom area and positioned in front of the TV. During the transfer, R71 was observed holding on to the handles on the side of the EZ stand and did not let go once she was sitting in the wheel chair. NA-A told R71 to let go of the handles and the resident did not. NA-A stated R71 was hard of hearing so, with the same gloved hands, NA-A patted R71's right hand and gestured to let go and then did the same with the left hand and with the cueing, R71 let go of the handles on the EZ lift. With the same gloves on used to provide incontinence/bowel cares, NA-A was asked about not removing the gloves. NA-A stated she just forgot to take them off and wash her hands after she cleaned R71. NA-A also stated she knew she should have but was nervous. NA-A used sani-wipes on the EZ lift handles that she used. -At 8:46 a.m. R71 was wheeled into the dining	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245236	A. BUILDING _____ B. WING _____	05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER	935 KENWOOD AVENUE DULUTH, MN 55811

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F 441	Continued From page 26 room and served breakfast, staff was observed to wash R71's hands before the meal was served. On 5/25/16, at 12:41 a.m. the DON verified NA-A should have removed the gloves immediately after cleaning R71 and then washed her hands before touching anything else. On 5/26/16, at 9:29 a.m. the clinical manager RN-B stated all nursing assistants know they need to change gloves and wash hands right away after completing incontinence care or at least use hand sanitizer.	F 441		

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	245236	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/25/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Benedictine Health Center 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 (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000	APPROVED Thom Linhoff By Tom Linhoff at 2:39 pm, Jun 17, 2016 RECEIVED JUN 17 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

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

B. Patto — Administrator — 6-17-16

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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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Benedictine Health Center is a three story building with no basement. The original building was constructed in 1980 with an addition in 1990. Both buildings are of type II(111) construction. Because the original building and the addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 96 beds	K 000		

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K 000	Continued From page 2 and had a census of 94 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has failed to maintain smoke/fire barrier doors in accordance with LSC 19.3.7.5. This deficient practice could affect 30 of 94 residents, staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 9:30 AM to 12:30 PM on 05/25/2016, observation revealed that the smoke barrier doors by resident room #8 had doors with a gap 1/4 of an inch which is greater than the maximum 1/8 of an inch between the meeting edges of the door leaves. This deficient practice was confirmed by the	K 027	K 027 1. Smoke barrier devices have been attached to doors to provide a maximum of 1/8 of an inch gap between meeting edges. See photos 2. Completion date was 5/27/16. 3. Larry Osborn environmental service director was responsible for the correction and will audit all existing smoke barrier doors for compliance. Any discrepancies will be reported to the Administrator and corrected by July 1st.	

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K 027	Continued From page 3 Maintenance Supervisor.	K 027		
K 052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4., 19.3.6.3.2, 19.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 94 of 94 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 9:30 AM to 12:30 PM on 05/25/2016, observations revealed that during the review of all available fire drill reports and fire alarm maintenance/testing documentation for the last 12 months and an interview with the Maintenance Supervisor, it was revealed that the facility failed to document and/or verify 4 of 12 monthly tests of the digital alarm communicator transmitter (DACT).	K 052	K 052 1. A fire drill was performed on 6/14/16 at 4:40 am. The monitoring service confirmed the test signal at 9:40 am. 2. Completion date 6/14/16 and ongoing. 3. Larry Osborn environmental service director was responsible for the drill and testing the alarm system. The practice for drills will remain the same between 9:00 pm to 6:00 am with a PA announcement. It will be followed up with the monitoring service confirming a test of sounding the alarm system after 6:00 am same day of fire drill.	

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K 052	Continued From page 4 This deficient practice was confirmed by the Maintenance Supervisor.	K 052		
K 104 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 5-1.2 and 5.2. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect 94 of 94 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 9:30 AM to 12:30 PM on 05/25/2016, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and confirmed by an interview with the Maintenance Supervisor, that the facility could not provide any current testing documentation verifying that the fire and smoke dampers has been tested or inspected within the last 4 years.	K 104	K 104 1. A contractor was called to complete the fire/smoke damper tests and is scheduled for 6/28/16. See letter of scheduled conformation. 2. The start date is actual and will continue tests and repairs if needed on any or all fire/smoke dampers until completion. 3. Larry Osborn environmental service director will be responsible for documentation of tests along with establishing an electronic reminder to have tests completed once every four years.	

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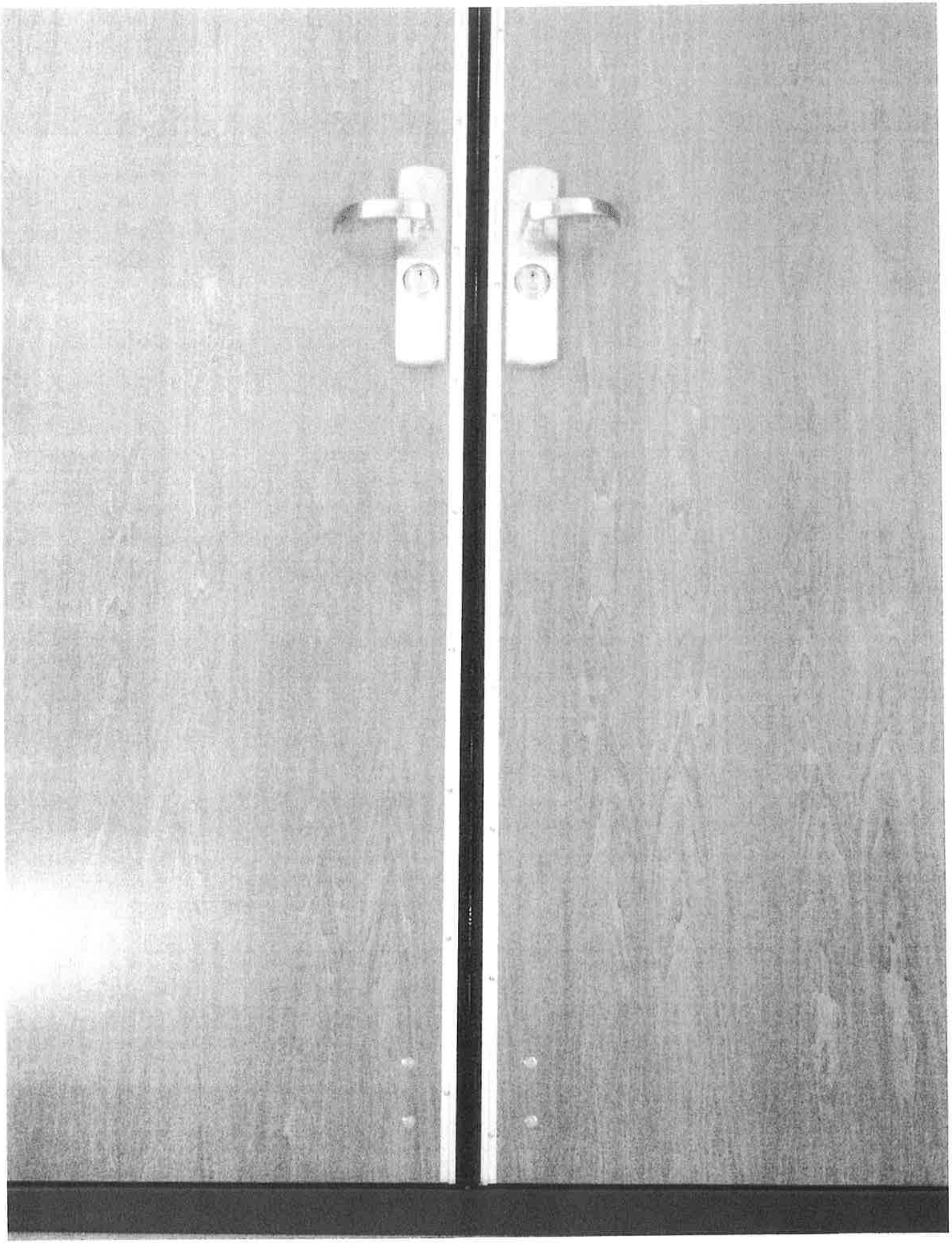
K 104	Continued From page 5 This deficient practice was confirmed by the Maintenance Supervisor.	K 104		



THE JAMAR COMPANY/4701 MIKE COLALILLO DR. ■ DULUTH, MN 55807-2762 ■ PHONE 218-628-1027 ■ FAX 218-628-1174

Benedictine Health
935 Kenwood Ave
Duluth, MN 55811

Larry,

This letter is to confirm that we are scheduled for a service call on June 28th, 2016 to Benedictine Health at the above address to complete approximately (33) Fire Damper Tests.

Thank you, and please let us know if you have any further questions.

Jacky Hause