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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

National Provider Identifier (NPI): 1740697291
CMS Certification Number (CCN): 245623

April 15, 2015

Sharon Johnson, Administrator
Benedictine Living Center Fridley
520 Osborne Road Northeast
Fridley, MN 55432

Dear Ms. Johnson:

The Centers for Medicare & Medicaid Services has accepted your request to participate as a skilled nursing facility in the Medicare program (Title XVIII of the Social Security Act). Your effective date of participation is **March 18, 2015**. A copy of the completed agreement is enclosed for your records.

Your National Provider Identifier (NPI) is your primary identifier for all health insurance billing. The NPI should be entered on all forms and correspondence relating to the Medicare program. In addition, you have been assigned the following CMS Certification Number (CCN): **245623**. Please provide it when contacting this office, when contacting the Minnesota Department of Health, or any time it is requested. National Government Services has been authorized to process your Medicare claims.

When you make general inquiries to your fiscal intermediary (FI) and/or Medicare Administrative Contractor (MAC), you will be prompted to give either your provider transaction access number (PTAN) or CCN. These identification numbers are used as authentication elements when inquiring about beneficiary- and claim-specific information. When prompted for your PTAN, give your CCN.

This agreement covers the 50 beds throughout the facility. Please be sure that patients are advised upon admission of those beds certified for Medicare coverage.

This Medicare certification is contingent upon compliance with Office for Civil Rights (OCR) requirements. If OCR approval is not obtained, reimbursement will be recouped as of the effective date of this provider agreement. You will be contacted again only if the necessary approval is not granted by the OCR.

If you are dissatisfied with the effective date of Medicare participation indicated above, you may request that the determination of the effective date be reconsidered. The request must be submitted in writing to this office within 60 days of the date you receive this notice. The request for reconsideration must state the issues or the findings of fact with which you disagree and the

reasons for disagreement.

Regulations at 42 CFR 489.18 require that providers notify CMS when there is a change of ownership. Therefore, you must notify this office promptly if there is a change in your legal status as owner of this facility. You should also report to the Minnesota Department of Health (MDH) any changes in staffing, services, or organization which might affect your certification status.

We welcome your participation and look forward to working with you in the administration of the Medicare program. If you have any questions, please contact me at (312) 886-5209.

Sincerely,

/s/

Jan Suzuki
Principal Program Representative
Long Term Care Certification
& Enforcement Branch

Enclosure: Provider Agreement (CMS-1561)

cc: Minnesota Department of Health
Minnesota Department of Human Services
National Government Services
Office of Ombudsman for Older Minnesotans
Stratis Health

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UXMV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 29890

1. MEDICARE/MEDICAID PROVIDER NO. (L1) INITIAL
2. STATE VENDOR OR MEDICAID NO. (L2)

3. NAME AND ADDRESS OF FACILITY
(L3) BENEDICTINE LIVING CTR FRIDLEY
(L4) 520 OSBORNE ROAD NORTHEAST
(L5) FRIDLEY, MN (L6) 55432

4. TYPE OF ACTION: 1 (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 03/18/2015 (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 FRTF 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 50 (L18)

13. Total Certified Beds 50 (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 ___6. Scope of Services Limit
___3. 24 Hour RN ___7. Medical Director
___4. 7-Day RN (Rural SNF) ___8. Patient Room Size
___5. Life Safety Code ___9. Beds/Room
B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(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:
Mary Beth Lacina, HFE NE II 03/19/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 03/20/2015 (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 (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. (L31)

30. REMARKS
Sent to CMS/(RO)_____
As an attachment in ACO.
Emailed CMS on 03/24/2015

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: Initial

An initial certification survey completed on March 18, 2015 found Benedictine Living Center of Fridley in compliance with health and life safety code requirements for Long Term Care Facilities. Certification recommended effective March 18, 2015, since all requirements are met.

Attached are the following documents: Health CMS-2567, Life Safety Code CMS-2567, CMS-2786R and crucial data extract, CMS-671, CMS-672, CMS-1561, email confirming Office for Civil Rights documents submitted, Transfer Agreement, CMS-855 including the approval letter from National Government Services dated August 28, 2014.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 19, 2015

Ms. Sharon Johnson, Administrator
Benedictine Living Center of Fridley
520 Osborne Road Northeast
Fridley, Minnesota 55432

Re: Initial Certification Survey

Dear Ms. Johnson:

An initial Medicare certification survey was completed at your facility on March 18, 2015 for the purpose of assessing compliance with Federal certification regulations. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division and Minnesota Department of Public Safety, were pleased to find that your facility was in full compliance with Federal certification regulations.

The Department will recommend certification to be effective as of the date of the survey.

Enclosed is your copy of the Federal Form CMS-2567 indicating your facility's compliance with the Federal regulations.

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

Thank you for your cooperation.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Certification Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29890	A. BUILDING _____ B. WING _____	03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CTR FRIDLEY	520 OSBORNE ROAD NORTHEAST FRIDLEY, MN 55432

(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 An Initial Certification survey was conducted on March 17, 18, 2015, by surveyors of this department. The facility was found to be in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. Certification is recommended	F 000		

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

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
	2429763	A. BUILDING 01 - MAIN BUILDING B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CENTER OF FRIDLEY	520 OSBORNE ROAD NORTHEAST FIRDLEY, MN 55432

(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
K 000	INITIAL COMMENTS FIRE SAFETY An Initial Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Benedictine Living Center of Fridley was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. Benedictine Living Center of Fridley is a 3-story building without a basement. The building was constructed in 2014 and was determined to be of Type II(111) construction. The building is has a full fire sprinkler system in accordance with NFPA 13, 1999 Ed. The facility has a fire alarm system with smoke detection in the corridors, by the smoke barrier doors, resident rooms and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 50 beds and had a census of 0 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

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.