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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: VD3S

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245360**
2.STATE VENDOR OR MEDICAID NO.
(L2) **448348100**

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

4. TYPE OF ACTION: **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) **02/01/2011**

6. DATE OF SURVEY 3/21/2013 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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
	62			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Brenda Fischer, Unit Supervisor 03/20/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 05/02/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/28/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5360

Post Certification Revisit, by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMA 2567B for both health and life safety code. Effective February 22, 2013, the facility is certified for 62 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5360 May 2, 2013

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

Dear Mr. Laine:

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

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

Effective February 22, 2013, the above facility is certified for:

62 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

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

March 22, 2013

RE: Project Number S5360024

Dear Mr. Laine:

On February 12, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 31, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 21, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 4, 2013 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 31, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 22, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 31, 2013, effective February 22, 2013 and therefore remedies outlined in our letter to you dated February 12, 2013, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900
Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245360	A. Building B. Wing	3/21/2013

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	02/20/2013	ID Prefix F0323 Reg. # 483.25(h) LSC	02/20/2013	ID Prefix F0465 Reg. # 483.70(h) LSC	02/20/2013
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/cbl	03/22/2013	10562	3/21/2013
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/31/2013			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245360	A. Building B. Wing 01 - MAIN BUILDING 01	3/4/2013

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 02/22/2013	ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 02/22/2013	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/cbl	03/23/2013	27200	03/04/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/29/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VD3S

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00314

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245360**
2.STATE VENDOR OR MEDICAID NO.
(L2) **448348100**

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

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

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

6. DATE OF SURVEY **01/31/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jessica Sellner, HFE NEII 02/27/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 03/28/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 3/28/2013 ML

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: 24-5360

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. Please refer to the CMS 2567 along with the facility's plan of correction. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 9240

February 12, 2013

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

RE: Project Number S5360024

Dear Mr. Laine:

On January 31, 2013, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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:

Brenda Fischer
Minnesota Department of Health
Midtown Square
3333 West Division, Suite #212
Saint Cloud, Minnesota 56301

Telephone: (320) 223-7338

Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 12, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 12, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. 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 May 1, 2013 (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 July 31, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

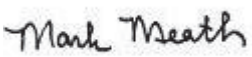
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7338 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File 5360s13.rtf

PRINTED: 02/12/2013
FORM APPROVED
OMB NO. 0938-0391

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

Received 2-22-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	01/31/2013

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

(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.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280	a. This resident no longer has his car on premises due to safety concerns. b. No other residents currently have personal vehicles. c. Policy regarding personal vehicles has been created and includes safety assessment prior to resident using vehicle while staying here, and personal escort to and from vehicle. d. Audits of documentation, including assessment, care planning, and compliance with facility policy will be conducted monthly for all residents with personal vehicles. Monitoring will be the responsibility of the DON or designee. Findings will be reported through the Quality Assurance Committee.	2/20/13

2/27/13 IA accepted

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

James G Lane | Administrator | 2/22/13

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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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	01/31/2013

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

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F 280	Continued From page 1 by: Based on interview and document review the facility failed to ensure 1 of 1 resident, R39, who was reviewed for safety had a current plan of care updated to ensure the resident was monitored according to physician orders. Findings include: R39 had diagnoses including alcoholism and chronic pain. The quarterly minimum data set (MDS) dated 12/26/12 identified the resident had no cognitive impairment and required supervision of walking on and off the unit. Review of R39's current physician orders dated January 2013, the resident had current pain medication orders including hydrocodone-acetaminophen (Vicodin) 5-500mg; 1-2 tabs PRN (as needed) and Oxycodone 10 mg every 12 hours as needed (PRN) for pain. Review of R39's progress notes indicated on 1/11/13 the facility had received a fax from the residents physician instructing to discontinue current scheduled Vicodin (pain medication), but continue the PRN Vicodin, and the resident was okay to drive only if he was not taking any pain medication. R39's current care plan dated 1/4/13 identified the resident was at risk for self-harm related to his poor decision making. The plan of care instructed staff to monitor for signs of alcohol use when returning from leave of absence (LOA), however, the care plan did not instruct staff to ensure the resident did not drive if taking pain medication as the physician had instructed. During interview on 1/30/13 at 9:00 a.m. R39 stated he brought his personal car with him to the facility and kept the keys in his top drawer in his room. He stated he can leave the facility whenever he wants and often "forgets to sign out"	F 280		

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F 280	Continued From page 2	F 280		

of the facility. R39 stated he enjoys going to the local bar to visit with old friends and the only rule the facility had was he could not drink alcohol and drive his vehicle. The resident did not know anything about not being able to drive after he took pain medication. R39 stated he had just driven his car the prior day, 1/29/13, to the local bar around 12:30 p.m. He stated he had not signed out of the facility before he left, and no one had asked him prior to leaving if he had taken any pain medication prior to driving his vehicle.

Upon review of R39's current Medication Administration record for January 2013, R39 received two tablets of hydrocodone-acetaminophen (Vicodin) 5-500mg at 8:15 a.m. on 1/29/13. Although the resident had received two tablets of pain medication (Vicodin) on 1/29/13, the resident stated he drove his vehicle around 12:30 p.m. that day.

During interview on 1/30/13 at 1:20 p.m. clinical manager (CM)-A stated she knew R39 drove 1/29/13 as she walked him out to his car because it was "icy" outside. CM-A was not aware the resident had taken pain medication prior to driving, and was not sure how the facility was supposed to be monitoring the resident to ensure he did not drive while taking pain medication. CM-A stated the resident would often just leave the facility in his vehicle without signing out in the sign out book or letting any of the nurses know. CM-A stated the facility usually "figured out" R39 had left the facility because his walker would be out in the parking lot next to where his vehicle is usually parked as he does not bring that with him in his vehicle.

Although R39 had physician orders to not drive if he was taking pain medication, the facility failed

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F 280	Continued From page 3 to ensure the residents plan of care was updated to ensure staff was monitoring the resident. No further information was provided.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure 1 of 1 resident, R39, who was reviewed for safety was monitored to ensure the resident was safe to leave the facility. Findings include: Resident (R)39 had diagnoses including alcoholism and chronic pain. The quarterly minimum data set (MDS) dated 12/26/12 identified the resident had no cognitive impairment and required supervision of walking on and off the unit. Review of R39's progress notes indicated on 1/11/13 the facility had received a fax from the residents physician instructing to discontinue current scheduled Vicodin (pain medication), but continue the PRN (as needed) Vicodin, and the resident was okay to drive only if he was not taking any pain medication. R39's current care plan dated 1/4/13 identified the resident was at risk for self-harm related to his	F 323	a. This resident no longer has his car on premises due to safety concerns. b. No other residents currently have personal vehicles. c. Policy regarding personal vehicles has been created and includes safety assessment prior to resident using vehicle while staying here, and personal escort to and from vehicle. d. Audits of documentation, including assessment, care planning, and compliance with facility policy will be conducted monthly for all residents with personal vehicles. Monitoring will be the responsibility of the DON or designee. Findings will be reported through the Quality Assurance Committee.	2/20/13

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F 323	Continued From page 4 poor decision making. The plan of care instructed staff to monitor for signs of alcohol use when returning from leave of absence (LOA), however, the care plan did not instruct staff to ensure the resident did not drive if taking pain medication as the physician had instructed on 1/11/13. During observation on 1/30/13 at 9:00 a.m. R39 was laying in his bed watching television. During interview on 1/30/13 at 9:00 a.m. R39 stated he brought his personal car with him to the facility and kept the keys in his top drawer in his room. He stated he can leave the facility whenever he wants and often "forgets to sign out" of the facility. R39 stated he enjoys going to the local bar to visit with old friends and the only rule the facility had was he could not drink alcohol and drive his vehicle. The resident did not know anything about not being able to drive after he took pain medication. R39 stated he had just driven his car the prior day, 1/29/13, to the local bar around 12:30 p.m. He stated he had not signed out of the facility before he left, and no one had asked him prior to leaving if he had taken any pain medication prior to driving his vehicle. Review of R39's current physician orders dated January 2013, the resident had current pain medication orders including hydrocodone-acetaminophen (Vicodin) 5-500mg; 1-2 tabs PRN (as needed) and Oxycodone 10 mg every 12 hours PRN for pain. R39's current Medication Administration record for January 2013, R39 received two tablets of hydrocodone-acetaminophen (Vicodin) 5-500mg at 8:15 a.m. on 1/29/13. Although the resident had received two tablets of pain medication (Vicodin) on 1/29/13, the resident stated he drove	F 323		

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

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F 323	Continued From page 5 his vehicle around 12:30 p.m. that day, 1/29/13. During interview on 1/30/13 at 9:50 a.m. licensed practical nurse (LPN)-A stated R39 was "his own person" and was able to drive his vehicle and come and go from the facility when he chose. LPN-A was not aware anytime R39 was not "allowed" to drive, and was not aware of the physician order regarding the resident not drive while taking pain medication. During interview on 1/30/13 at 9:55 a.m. registered nurse (RN)-A stated R39 had the keys to his car and can leave the facility when he wants. She stated the resident had been told to not take pain medication and drive. She was not aware that R39 had taken his pain medication and driven on 1/29/14. RN-A was not aware of how the facility was currently monitoring R39 regarding taking pain medication and driving. During interview on 1/30/13 at 12:55 p.m. physician (P)-A, who is R39's physician, stated R39 should not be driving when taking any of his pain medication, which is why the order was written. P-A stated the facility had not notified her R39 had driven after taking pain meds on 1/29/13, and she was not aware the resident had driven his vehicle at all in the last month. P-A stated the facility should be monitoring R39 to ensure he does not drive while taking pain medications. During interview on 1/30/13 at 1:05 p.m. LPN-B stated R39 does not sign out and let the nurses know when he leaves the building, however, she was not aware the resident had left the building for "a long time." She indicated the resident is independent so there are no specific guidelines they need to be monitoring him for regarding driving his personal vehicle. During interview on 1/30/13 at 1:07 p.m. nursing	F 323		

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F 323	Continued From page 6 assistant (NA)-A stated she saw R39 leave the building in his vehicle "yesterday around 1:00 p.m." She told the resident to tell his nurse, but she was unsure if the resident told anyone he was leaving the building. During interview on 1/30/13 at 1:20 p.m. clinical manager (CM)-A stated she knew R39 drove 1/29/13 as she walked him out to his car because it was "icy" outside. CM-A was not aware the resident had taken pain medication prior to driving, and was not sure how the facility was supposed to be monitoring the resident to ensure he did not drive while taking pain medication. CM-A stated the resident would often just leave the facility in his vehicle without signing out in the sign out book or letting any of the nurses know. CM-A stated the facility usually "figured out" R39 had left the facility because his walker would be out in the parking lot next to where his vehicle is usually parked as he does not bring that with him in his vehicle. Although R39 had physician orders to not drive if he was taking pain medication, and the care plan instructed staff to monitor for signs of alcohol use when returning from leave of absence (LOA), the facility did not have a system in place to monitor the resident to ensure his safety. No further information was provided.	F 323		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced	F 465	a., b. Identified rooms have been inspected and evaluated for risk for injury to residents/staff. Repairs will be completed based on this prioritized list.	2/22/13

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F 465	Continued From page 7 by: Based on observation and interview, the facility failed to provide housekeeping to ensure resident bathrooms and resident tub/shower room floors were maintained in a sanitary manner, potentially affecting all 48 residents who resided in the facility. In addition the facility failed to maintain resident room and resident bathroom door trim to ensure a cleanable surface, and to prevent injuries potentially affecting 42 residents who currently reside in the facility. Findings include: During the environmental tour on 1/31/12 at 9:30 a.m. with the facilities maintenance director (MD) and housekeeping (HSK)-A, the following was noted and verified: Pine Lane's tub/shower room floor had wax build up with black dirt stuck in it, around the perimeter of the tub and shower area. The toilet had cracked and missing caulking along the floor, which had black dirt stuck in it, all the way around the base. Room 108's and room 116's bathroom floors had two black strips stuck to the floor, that were worn and torn, black dirt was stuck around the edges. In addition there was wax build up around the toilet and perimeter of the bathroom in which dirt was stuck. Resident rooms 103, 105, and 111 bathroom floors had wax build up with dirt stuck in around the perimeter of the room as well as around the toilet.	F 465	c. Environmental inspection checklist will completed with weekly deep cleaning to be turned in to ESD for review. d. Audits of completion of checklists will be performed monthly for 3 months, then quarterly. Monitoring will be the responsibility of the ESD or designee. Findings will be reported through the Quality Assurance Committee.	

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F 465	Continued From page 8 Maple Lane's tub/shower room had wax build up around the perimeter and around the shower, toilet and tub with black dirt stuck in it. HSK-A stated housekeeping mops floors weekly, but these items "need a good scrubbing." MD stated "we need to do a better job with cleaning." The following resident room doors and bathroom doors had plastic molding that went from the floor to approximately three feet up. The plastic molding had come loose and was pulled away from the door frame. This created an unwashable surface and included rooms: 101, 102, 105, 106, 108, 109, 110, 118, 119, 120, 121, 123, 124, 126, 127, 128, 129, 130, 132, 133, 134, 142, and 143. Room's 111 had broken molding around the bathroom door that was chipped in multiple areas with sharp edges, and pieces sticking out form the frame, this had to potential to injure skin. Room 118's bathroom door's molding was also broken up at the top with a three inch area protruding out with sharp edges. MD stated the molding must get hit by the lifts or wheel chairs and verified it was a potential hazard. On 1/31/13 at 10:45 a.m. the administrator stated the facility has ongoing maintenance of items in need of repair, however he was not aware of all the broken, loose molding in resident rooms. A facility policy was requested, but not provided.	F 465		

F 536 0021

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	245360	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/29/2013

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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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Benedictine Living Community of New London was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	RECEIVED FEB 25 2013 MINNESOTA DEPARTMENT OF PUBLIC SAFETY POC ok JB 2-25-13	

DC: 03.03.2013

EXIT: 1.22.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
James E Lauer	ADMINISTRATOR	2/22/13

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 By e-mail to: Barbara.lundberg@state.mn.us and Marian.Whitney@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 Living Community of New London is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1964 and was determined to be of Type II(000) construction. In 1993 and addition was added to the south of the Service Wing that was determined to be of Type II(000) construction. In 1996 and addition was added to the north of the Service Wing that was determined to be of Type II(000) construction. In 1999 and addition was added to the south of the 1993 addition that was determined to be of Type II(000) construction. Because the original building and the 3 additions ae of the same type construction the facility was surveyed as one building. The building is fully protected by a fire sprinkler	K 000		

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K 000	Continued From page 2 system. The facility has a 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 62 beds and had a census of 48 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations, the facility has failed to provide proper protection for 2 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. The following deficient practices could affect residents, staff and visitors as smoke and fire in these rooms could enter the corridor making it untenable. Findings include:	K 029	1. Areas of potential penetration have been covered by NFPA approved material within both the mechanical and sprinkler riser rooms. 2. Any further construction by external contractors will be inspected by Environmental Services Director to ensure compliance with NFPA standards. 3. Correction and monitoring by the Environmental Services Director.	2/22/2013

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/29/2013

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

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K 029	Continued From page 3 On facility tour between 10:30 AM to 12:30 PM on 01/29/2013, observations revealed that there were multiple penetrations around the electrical conduit by the door on the inside of the mechanical room near resident room 159. There was also a 4 inch hole located in the wall of the sprinkler riser room. This deficient practice was verified by the Maintenance Supervisor (BN).	K 029		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 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 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 2-3.4.5.1.2, 2-3.5.1. 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	K 052	1. Procedure for fire drills has been amended to include activation of the DACT system with every drill. 2. Fire drill form has been amended to include this change to prevent recurrence of omission. 3. Correction and monitoring by the Environmental Services Director.	2/22/2013

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/29/2013

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K 052	Continued From page 4 affecting all residents, staff, and visitors of the facility. Findings include: On facility tour between 10:30 AM to 12:30 PM on 01/29/2013, during a documentation review of the available fire drill reports and fire alarm testing documentation for the last 12 months and interview with the Maintenance Supervisor (BN), it was revealed that the facility failed to conduct 1 of 12 monthly tests of the fire alarm DACT system. This deficient practice was verified by the Maintenance Supervisor (BN).	K 052		