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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZNFF

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 **07/15/2014** (L34)
07/18/2014

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 **120** (L18)

13.Total Certified Beds **120** (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
	120			
(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):

17. SURVEYOR SIGNATURE Date :
Jessica Sellner, Unit Supervisor 07/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 07/25/2014 (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
11/17/1980
(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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5236

July 24, 2014

Ms. Katie Redig, Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, Minnesota 55811

Dear Ms. Redig:

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 1, 2014 the above facility is certified for:

120 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 120 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 letter.

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 24, 2014

Ms. Katie Redig, Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, Minnesota 55811

RE: Project Number S5236025

Dear Ms. Redig:

On June 11, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 22, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On July 15, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 18, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 22, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 1, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 22, 2014, effective July 1, 2014 and therefore remedies outlined in our letter to you dated June 11, 2014, will not be imposed.

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

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

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

Sincerely,

Mark Meath

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

Enclosure

cc: Licensing and Certification File 5236r14.rtf

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
245236	A. Building B. Wing	7/15/2014

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **07/01/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **07/01/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **07/01/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **07/01/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/mm	07/24/2014	29249	07/15/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/22/2014			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245236	A. Building B. Wing **01 - MAIN BUILDING 01**	7/18/2014

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0144	**06/05/2014**	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		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/mm	Date: 07/24/2014	Signature of Surveyor: 03005	Date: 07/18/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 5/22/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ZNFF

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 **05/22/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **120** (L18)

13.Total Certified Beds **120** (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
	120			
(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):

17. SURVEYOR SIGNATURE — Date :
Nicolle Marx, HFE NEII — 07/08/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 07/24/2014 (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
11/17/1980
(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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3698

June 11, 2014

Ms. Katie Redig, Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, Minnesota 55811

RE: Project Number S5236025

Dear Ms. Redig:

On May 22, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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:

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:

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557

Phone: (320) 223-7345
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 July 1, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 1, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. 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 22, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 22, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File 5236s14.rtf

BENEDICTINE HEALTH CENTER
Benedictine Health System

LONG-TERM NURSING CARE
SAFE HARBOR ADVANCED MEMORY CARE
SHORT-TERM CARE & REHABILITATION CENTER
OUTPATIENT THERAPY
RESPITE CARE
ADULT DAY SERVICES
MS ACHIEVEMENT CENTER
STAY FIT WELLNESS CENTER
WESTWOOD INDEPENDENT LIVING APARTMENTS
WESTWOOD ASSISTED LIVING APARTMENTS
WESTWOOD TERRACE ASSISTED LIVING MEMORY CARE SUITES
EARLY CHILDHOOD PROGRAM
DEVELOPMENTAL PRESCHOOL

Addendum to Plan of Correction:

F 167- the survey binder will be audited by the DON/designee weekly X's two month and then monthly to begin immediately following receipt of accepted Plan of Correction.

F282 and F 309- Audits will be monitoring for the following: use of the new form, amount distributed by dietary/nursing is listed on the form, initials and signatures are present, totals for 8/24 hours, night shift is completed per policy/procedure, no water glasses or pitchers are in the resident's room and meal boards contain documentation for all residents for each meal.

Katie Redig, Administrator/CEO

7-2-14
Date

RN 7-8-14

PH 218 723 6408
FX 218 725 6449

935 KENWOOD AVE
DULUTH, MN 55811

WWW.FACEBOOK.COM/BHCDULUTH

WWW.BHCDULUTH.ORG

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 _____	05/22/2014

RECEIVED
JUN 30 2014
MN Dept of Health St.Cloud

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.	F 000	Jessica Dean 7.8.14	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the most recent Federal survey results and plan of correction were posted and readily available. This had the potential to affect all 112 residents residing in the facility, as well as all family and visitors. Findings include:	F 167	**F 167:** Survey results for 2013 were posted by the end of the day on 5/19/14. Updates will be posted as soon as the document is final and available for posting. Document is posted in the main lobby area in a plastic cover near the main elevator. **Completion date: July 1, 1014**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator/CEO — (X6) DATE: 6-27-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245236	A. BUILDING _____ B. WING _____	05/22/2014

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BENEDICTINE HEALTH CENTER	935 KENWOOD AVENUE DULUTH, MN 55811

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F 167	Continued From page 1 During the initial tour of the facility on 5/19/14, at 2:53 p.m., a plastic protective sleeve identified as having the survey results was observed in a wall mounted three tiered holder, which was located to the left of the elevator on the main level of the facility. Observation of the papers inside the plastic sleeve were the facility survey results posted from the 2012 recertification survey, and not the most recent 2013 survey. During an interview on 5/19/14, at 3:01 p.m., administrative assistant (AA)-F verified the survey results were from the 2012 survey, and stated, "There must be a newer one." AA-F stated she had the most recent survey results on her computer and the director of nursing (DON) had a copy in her office. AA verified the 2012 survey posting was the only posting available for residents and visitors to review. During an interview on 5/21/14, at 8:20 a.m., the DON stated the 2012 survey results were the only ones available in the facility for the residents and public to review. The DON stated she was not sure why the most recent survey results from 2013 were not posted.	F 167		
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:	F 282	**F 282: R 196's** documentation of the 1500 cc fluid restriction was started immediately upon discovery to include totals per shift and at 24 hours. Night shift documentation was corrected to include any observable fluid intake. The facility will ensure that all residents on a Fluid Restriction will be identified	

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F 282	Continued From page 2 Based on observation, interview and document review, the facility failed to ensure staff implemented the written plan of care related to monitoring fluid intake for 1 of 1 dialysis residents (R196) who received dialysis at an outside facility. Findings include: R196's diagnoses identified on the care plan dated 3/24/14, included chronic kidney disease, diabetes, and renal dialysis. The admission Minimum Data Set (MDS) dated 3/19/14, identified R196 had moderate cognitive impairment. A Care Area Assessment (CAA) for Nutritional Status dated 3/24/14, indicated R196 was noncompliant with the prescribed diet. A physician order dated 4/16/14, indicated R196 was to have a 1500 (ml) milliliter fluid restriction daily and directed staff to record the intake on a flow sheet in the medication administration record (MAR) every shift. The physician order indicated 900 ml of fluid were to be distributed by dietary with meals, and the remaining 600 ml were to come from nursing. R196's care plan dated 3/24/14, directed staff to monitor for changes in fluid intake and identified the resident was on a 1500 ml fluid restriction related to dialysis. The nursing assistant care guide (which the nursing assistants use to provide cares to residents), undated, indicated R196 was on a fluid restriction. Review of the fluid intake record dated 4/1/14-4/30/14, out of the 30 opportunities, evening shift docoumented fluid intake 7 days, and nights documented 5 days. Out of the 30 days in April 2014, there were no days recorded of total fluid	F 282	and cared for in accordance with our Fluid Restriction Policy/Procedure. The policy was reviewed for accuracy and staff education completed on June 25, 2014. All residents on a fluid restriction will be monitored closely and documented per Policy/Procedure. . The intake form was revised to include the amount to be distributed by dietary and nursing. Totals were added for each shift and at 24 hours. The nursing staff monitor, report and document the intake of any resident on a fluid restriction and keep totals at 8 and 24 hour intervals. Monitoring will include audits to be performed 5x's/week by the DON or designee. Audit results will be brought to the Quality Council for review and for any further recommendations. The administrator and DON will be responsible for compliance. **Completion date: July 1, 2014**	

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F 282	Continued From page 3 intake for R196. Fluid intake record for 5/1/14 through 5/21/14, out of the 21 days there no days which included fluid intake total, nor was there documentation or any assessment to ensure the plan of care was being followed related to the residents fluid restriction. In addition, out of 21 opportunities, evening shift only documented fluid intake 4 times, and nights did not document any of the 21 days of R196's fluid intake. An interview on 5/21/14, at 12:07 p.m., registered dietician (RD) stated nursing should be monitoring fluid intakes for residents who had fluid restriction. RD stated if staff was not documenting and assessing fluids daily, staff would not know if R196 was following the care planned fluid restriction. RD verified the fluid intake records lacked documentation related to R196's fluid intake and could not determine if the resident was following the fluid restriction. During interview on 5/22/14, at 9:15 a.m. R196 stated she received dialysis three times a week at an outside facility. R196 was unaware of any fluid restrictions that needed to be followed. During observation on 5/22/14, at 9:15 a.m. R196 had a 240 ml cup sitting on the table which was empty. R196 stated the cup had water and ice in it prior and she had drank all of it. The resident stated staff does not talk to her regarding how much fluid she drinks. The facility policy titled Fluid Restriction, dated 5/2014, indicated a fluid intake and output record would be maintained for a resident with fluid restriction order. The policy also indicated each shift nursing staff would monitor, report, document fluid intake and output and staff were	F 282		

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F 282	Continued From page 4 to total fluid intake after 24 hours and record the amount.	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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure coordination of care with an outside dialysis unit, related to the monitoring of fluid intake for 1 of 1 resident (R196) reviewed who required hemodialysis services. Findings include: R196's admission Minimum Data Set (MDS) dated 3/19/14, identified the resident had moderately impaired cognition, with diagnoses including chronic kidney disease, diabetes and renal dialysis. A Care Area Assessment (CAA) dated 3/24/14, indicated R196 was noncompliant with her prescribed diet. R196's care plan dated 3/24/14, directed staff to monitor for changes in fluid intake and identified the resident was on a 1500 milliliters (ml) fluid restriction related to dialysis. The undated nursing assistant (NA) care sheet indicated R196 was on	F 309	**F309: R 196's** fluid restriction documentation was immediately corrected to include totals at the end of 8 and 24 hours and documentation each shift. Resident 196's Care Plan was reviewed to ensure coordination of care with outside dialysis unit. Communication with the dialysis unit is done via a communication referral form and additional updates are completed through phone calls or faxes. Failure to monitor for any water glasses or pitchers in the resident's room was corrected immediately. The facility will ensure that all residents on a Fluid Restriction will be identified and cared for in accordance with our Fluid Restriction Policy/Procedure. The Fluid Restriction Policy/Procedure was reviewed and staff education completed on June 25, 2014. Audits will be completed 5 x's weekly by the DON/designee. Audit results will be brought to the Quality Council for review and for any further recommendations. The Administrator and DON will be responsible for compliance. **Completion date: July 1, 2014**	

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F 309	Continued From page 5 a fluid restriction. A physician order dated 4/16/14, indicated R196 was to have a 1500 ml fluid restriction daily and directed staff to record the intake on a flow sheet in the medication administration record (MAR) every shift. The physician order indicated 900 ml of fluid were to be distributed by dietary with meals and the remaining 600 ml were to come from nursing. A communication form from R196's dialysis unit dated 4/21/14, instructed, "Please watch fluid intake." Review of R196's fluid intake record dated 4/1/14, through 4/30/14, indicated the following: - R196's fluid intake was documented on 7 of the 30 opportunities during the evening shift. - Night shift documented fluid intake for 5 out of the 30 opportunities available. R196's total daily fluid intake was not documented during any of the 30 days in April 2014. Review of R196's fluid intake record dated 5/1/14, through 5/21/14, revealed the following: - R196's fluid intake was only documented on four out of the 21 opportunities during the evening shift. - No fluid intake was documented during the night shift, out of the 21 opportunities. - R196's total daily fluid intake was not documented during any of the 21 days. The record lacked evidence of a tracking system to communicate R196's fluid intake across shifts and to evaluate whether her prescribed fluid restriction had been followed.	F 309		

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F 309	Continued From page 6 A communication form from R196's dialysis unit dated 5/16/14, instructed, "Please help [R196] monitor fluid intake." During interview on 5/21/14, at 12:07 p.m. registered dietician (RD) stated nursing staff were responsible for monitoring fluid intake for residents who were on a fluid restriction. RD confirmed if staff were not documenting and assessing fluids daily, they would not know whether R196 was following her prescribed fluid restriction or whether she was receiving sufficient amount of fluids. RD reported R196 was receiving a diuretic in addition to her fluid restriction, which put her at risk for dehydration if she was not consuming enough fluids. RD verified R196's fluid intake record lacked sufficient documentation of her fluid intake to determine whether she had received an appropriate amount of fluids, consistent with her physician's order. During interview and observation on 5/22/14, at 9:15 a.m., R196 stated she received dialysis three times a week at an outside facility. R196 was unaware of any fluid restrictions that needed to be followed and she denied staff talked with her to inquire on what fluid she had consumed. An empty 240 ml cup was observed sitting on R196's table. R196 reported the cup had contained water with ice, but she drank all of it. During interview on 5/22/14, at 9:48 a.m. registered nurse (RN)-C confirmed staff were instructed to document R196's intake during meals on a flow sheet, with nursing reviewing those intakes. RN-C stated staff were also supposed to chart the amount of fluid R196 had consumed each shift in the MAR. RN-C verified	F 309		

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F 309	Continued From page 7 staff had not been documenting the amount of fluids consumed each shift or the amount consumed during meals. RN-C stated staff should have known the amount of fluids R196 was drinking and should have followed the care plan. The facility's Fluid Restriction policy dated 5/14, indicated a fluid intake and output record was to be maintained for a resident with a fluid restriction order. The policy added, each shift of nursing staff were to monitor, report and document fluid intake and output. The policy directed staff to total the fluid intake after 24 hours and record the total amount.	F 309		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to	F 431	**F 431:** All identified expired medications were identified and destroyed immediately per facility Non-Controlled Medication Disposal Policy /Procedure. The facility Policy /Procedure for Medication Disposal was reviewed. The refrigerator log was reviewed and revised to include a place for the night nurse to sign off on the checking of expired medications in med room refrigerator. All other inventory will be tracked and disposed of per policy by our Purchasing department head. Education to staff was completed June 25, 2014.	

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F 431	Continued From page 8 have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to establish a system to ensure expired medications were removed from stock supply, as evidenced by 2 of 7 medication carts and 2 of 4 medication storage rooms, where expired medications remained available for use. This system had the potential to affect all 112 residents whose medications were administered by the facility, along with any newly admitted residents or new employees who received Tubersol (a medication used to aid in the diagnosis of tuberculosis) as part of the facility's tuberculosis screening procedure. Findings include: The following concerns were identified during observation of the facility's medication storage system: On 5/20/14, at 11:20 a.m. the Safe Harbor unit medication storage room was observed with one, open multi-dose vial of Tubersol, which noted an open date of 7/12/13 (opened for a period of	F 431	Audits will be completed 5 x's weekly by the DON /designee to include monitoring of the expired medications on the Medication carts and also in medication/storage areas. Audit results will be brought to the Quality Council for review and for any further recommendations. The Administrator and DON will be responsible for compliance. **Completion date: July 1, 2014**	

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F 431	Continued From page 9 greater than ten months). The vial was located in a locked box, inside the refrigerator and remained available for use. Trained medication aid (TMA)-A was present at the time of observation and stated she was unsure the length of time this medication could be used after it was opened. Review of the Sanofi Pasteur (Tubersol manufacturer) guidelines dated 3/13, directed, "A vial of Tubersol which has been entered and in use for 30 days should be discarded." On 5/21/14, at 12:01 p.m. the third floor Pod Three medication cart was observed with a bottle of Mucus Relief Guaifenesin 400 milligrams (mg), with an expiration date of 3/14. LPN-D was present at the time of observation and verified the product was expired, but remained available for use. On 5/21/14, at 12:21 p.m. the third floor Pod Two medication cart was observed with a bottle of Loratadine 10 mg and a bottle of Mucus Relief Guaifenesin 400 mg. Both bottles had expiration dates of 3/14. LPN-F was present at the time of observation and stated the products were expired, but remained available for use. On 5/22/14, at 9:45 a.m. the third floor medication storage room was observed with a bottle of Geri-Mox Antacid and Antigas, with an expiration date of 12/13. Furthermore, the storage room refrigerator included four vials of Adult Recombivax HB Hepatitis B vaccination, with expiration dates of 4/6/14. Registered nurse (RN)-D was present at the time of observation and stated these products were expired, but remained available for use.	F 431		

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F 431	Continued From page 10 During interview on 5/22/14, at 10:10 a.m. the director of nursing (DON) verified the above noted medications were expired, but remained available for use. The DON stated she was not familiar with the facility's process to ensure expired stock supply medications were not administered to residents. The facility's standing medication orders revised 10/09, included the following: Mantoux two-step (Tubersol) if known not positive on admission; Guaifenesin 10 milliliters (ml) (Mucus Relief Guaifenesin 400mg), every four hours for cough; and Maalox/Mylanta (Geri-Mox Antacid and Antigas) 15 ml every three hours as needed for gastric upset. The facility's undated Storage of Medications policy, directed, "Outdated, contaminated, or deteriorated medications...are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists."	F 431		

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

F5236022

PRINTED: 06/11/2014
FORM APPROVED
OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION 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, on May 22, 2014. At the time of this survey, Benedictine Health Centerwas 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: State Fire Marshal Division Health Care Inspections 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-514, AND	K 000	POC pk 1-8-14 RECEIVED JUL - 7 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO Administrator | (X6) DATE: 6-27-14

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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
K 000	Continued From page 1 By E-Mail to 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 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 120 beds and had a census of 115 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT met as evidenced by:	K 000		
K 144	NFPA 101 LIFE SAFETY CODE STANDARD	K 144	K-144 A licensed electrician completed an emergency generator test on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245236	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 144 SS=F	Continued From page 2 Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on a review of available documentation, it could not be verified that the emergency generator is being properly inspected and reference the 30% rule monthly as required by NFPA 110. Nor is the generator monitored at a 24/7 location. This deficient practices could affect all building occupants Findings include: At the conclusion of the facility tour on 5-22-14 at 10:30 AM, Based on interview, and review of the documentation, with the Facility Maintenance Director, it could not be determined, if the emergency generator is being inspected and tested monthly in accordance with the requirements as outline in NFPA 110. This would include the monthly 30% load testing. The generator is a 200 KW, fueled by diesel fuel. Further it was discovered that the generator run functions are not monitored at a 24/7 occupied location. This deficient practice was confirmed by the Director of Facility Maintenance(LO) at the time	K 144	6/5/2014. Education to this test was provided to the Maintenance department. A log verifying completion of this test to include inspection and reference to the 30% load testing was initiated immediately. The 24/7 location for monitoring of the generator was identified to be second floor behind the nurses station. This location can be referenced in the Fire, Building, & Life Safety Code book . **Completion date: ~~July 1, 2014~~**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 144	Continued From page 3 of exit.	K 144		