



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered  
September 28, 2026

Administrator  
ST BENEDICTS CARE CENTER  
1810 MINNESOTA BOULEVARD SOUTHEAST  
SAINT CLOUD, MN 56304

RE: CCN: 245350  
Cycle Start Date: August 6, 2026

Dear Administrator:

On September 25, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, MN 55164-0900  
Telephone: 651-201-4308    Fax: 651-215-9697

Email: [sarah.lane@state.mn.us](mailto:sarah.lane@state.mn.us)



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 27, 2026

Administrator

St. Benedicts Care Center

1810 Minnesota Boulevard Southeast

Saint Cloud, MN 56304

RE: CCN: 245350

Cycle Start Date: August 6, 2026

Dear Administrator:

On August 6, 2026, a 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

If an acceptable ePoC 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

## **DEPARTMENT CONTACT**

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

Judy Loecken, Regional Operations Supervisor  
 St. Cloud B District Office  
 Health Regulation Division  
 Minnesota Department of Health  
 4140 Thielman Lane  
 Saint Cloud, Minnesota 56301-4557  
 Email: [judy.loecken@state.mn.us](mailto:judy.loecken@state.mn.us)  
 Office: (320) 223-7300 Mobile: (320) 426-0175

## **PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

## **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

## **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 *November 6, 2026* (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).

In addition, if substantial compliance with the regulations is not verified by *February 6, 2027* (six months after the identification of noncompliance), your provider agreement will be terminated. 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.

**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.**

## **INFORMAL DISPUTE RESOLUTION (IDR)**

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

### **INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)**

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens  
State Fire Safety Supervisor  
Health Care & Correctional Facilities  
MN Department of Public Safety-Fire Marshal Division  
445 Minnesota St., Suite 145  
St. Paul, MN 55101  
Email: [travis.ahrens@state.mn.us](mailto:travis.ahrens@state.mn.us)  
Web: [www.sfm.dps.mn.gov](http://www.sfm.dps.mn.gov)  
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
Office: 651-201-4384  
Email: [holly.zahler@state.mn.us](mailto:holly.zahler@state.mn.us)

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTIONS         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245350 |  | (X2) MULTIPLE CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING                                                       |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br>08/06/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>ST BENEDICTS CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1810 MINNESOTA BOULEVARD SOUTHEAST , SAINT CLOUD, Minnesota,<br>56304 |                                                                                                                          |                                              |                            |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                     |  | ID<br>PREFIX<br>TAG                                                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                              | (X5)<br>COMPLETION<br>DATE |
| E0000                                                        | Initial Comments<br><br>On 8/3/26 through 8/6/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.                                                                                                                                                                                                                                                                                                                                     |                                                                     |  | E0000                                                                                                              |                                                                                                                          |                                              | 08/27/2026                 |
| F0000                                                        | INITIAL COMMENTS<br><br>On 8/3/26 through 8/6/26, a standard recertification survey (S5350040-0) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed: NO deficiencies were cited.<br><br>H53503584C/2686474<br><br>H53503583C/2974711<br><br>H53503586C/2655688<br><br>H53503585C/2658612<br><br>H53503582C/3120885<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. |                                                                     |  | F0000                                                                                                              |                                                                                                                          |                                              |                            |

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 reverse for further 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.

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

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| NAME OF PROVIDER OR SUPPLIER<br><br>ST BENEDICTS CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1810 MINNESOTA BOULEVARD SOUTHEAST , SAINT CLOUD, Minnesota, 56304 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                              |                            |
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| F0000                                                        | Continued from page 1<br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.<br><br>The facility is enrolled in ePOC, therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                  |  | F0000                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                              | 08/27/2026                 |
| F0812<br>SS = E                                              | Food Procurement,Store/Prepare/Serve-Sanitary<br><br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br><br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and document review, the facility failed to ensure refrigerated food items were properly labeled, dated, and closed after the packaging was opened to prevent cross contamination which had the potential to affect all 45 residents currently residing on the second floor.<br><br>Findings Include:<br><br>During observation and interview on 08/03/2026 at 10:28a.m., dietary assistant (DA)-A and surveyor reviewed contents of the Parker's Lane kitchenette |                                                                  |  | F0812                                                                                                           | F0812 – Food Procurement, Store/Prepare/Serve - Sanitary<br><br>SS = E<br><br>Findings Include:<br><br>Detailed description of the corrective action taken or planned to correct the deficiency.<br><br>All unlabeled, opened, or undated food items were immediately discarded.<br><br>A full-house audit was completed to ensure there were no additional unlabeled, undated, or improperly stored food items in other areas.<br><br>Address the measures that will be put in place to ensure the deficiency does not reoccur:<br><br>All culinary team members will receive education on the importance of properly labeling and dating food items in accordance with food safety and sanitation requirements.<br><br>Audits will be completed in all kitchenettes weekly for three consecutive weeks, followed by monthly audits for two additional months to ensure sustained compliance. Audit results will be reviewed by the QAPI Committee, and any identified deficiencies will be addressed promptly.<br><br>Identify who is responsible for the corrective actions and monitoring of compliance. |                                              | 09/18/2026                 |

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| F0812<br>SS = E                                              | <p>Continued from page 2<br/>on second floor. DA-A verified the following concerns identified in the refrigerator freezer:</p> <p>-one hamburger patty in a plastic bag, left open, undated</p> <p>-one omelet in plastic bag, undated</p> <p>-one French toast in plastic bag, undated</p> <p>-five waffles in plastic bag, left open, undated</p> <p>-multiple pancakes in plastic bags, one bag left open, undated</p> <p>-two macaroni and cheese items wrapped in plastic, undated</p> <p>During observation and interview on 08/03/2026 at 10:38a.m., DA-B and surveyor reviewed contents of the Therapy Suite's kitchenette on second floor. DA-B stated foods in refrigerators and freezers were supposed to be dated. DA-B verified the following concerns identified in refrigerator freezer:</p> <p>-multiple corn dogs in plastic bag, undated</p> <p>-multiple hamburger patties in plastic bag, undated</p> <p>-multiple pancakes in plastic bag, undated</p> <p>-multiple omelets in plastic bag, undated</p> <p>-multiple hot dogs in plastic bag, undated</p> <p>-multiple waffles in plastic bags, one bag left open, undated. DA-B removed waffles in open bag, taped bag closed and returned to freezer.</p> <p>During interview on 8/4/26 at 10:00 a.m. dietary manager (DM)-A indicated all food items should be dated if to be stored for longer than one day. DM-A stated it was important to date items to assure facility was using food first in- first out, and that it could be a potential problem if food items became old. DM-A also stated if bags were left open cross contamination could be possible.</p> <p>The facility policy titled Food Storage dated 5/25, identified sufficient storage facilities would be provided to keep foods safe, wholesome, and appetizing. Frozen foods should be covered, labeled and dated. All foods would be checked to ensure that foods would be consumed by their safe use by dates or discarded.</p> |                                                                  |  | F0812                                                                                                           | <p>Continued from page 2</p> <p>Culinary Director, or Designee.</p> <p>The actual or proposed date for completion of the remedy.</p> <p>09/18/2026</p> |                                              | 09/18/2026                 |

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| NAME OF PROVIDER OR SUPPLIER<br><br>ST BENEDICTS CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1810 MINNESOTA BOULEVARD SOUTHEAST , SAINT CLOUD, Minnesota, 56304 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                              |                            |
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| F0572<br>SS = D                                              | <p>Notice of Rights and Rules</p> <p>CFR(s): 483.10(g)(1)(16)</p> <p>§483.10(g) Information and Communication.</p> <p>§483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.</p> <p>§483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.</p> <p>(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.</p> <p>(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.</p> <p>(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure the most up to date Nursing Home Resident Bill of Rights (RBOR) was provided to each resident residing in the facility and displayed for residents, visitors, and staff to review. This had the potential to affect all 71 residents currently residing in the facility as well as all staff and visitors.</p> <p>Findings include:</p> <p>During interview on 8/4/26 at 11:23 a.m. R19 stated the Bill of Rights was posted on the first floor but did not recall anyone sitting down and going over the bill of rights</p> <p>During observation on 8/4/26 at 11:26 a.m. displayed on first floor across from the kitchen door was the RBOR dated 7/1/07.</p> <p>On 8/4/26 at 11:33 a.m. reviewed facility admission packet, the packet included RROB indicated it was revised 11/28/16, modified 2/1/17.</p> |                                                                  |  | F0572                                                                                                           | <p>F0572 – Notice of Rights and Rules</p> <p>SS = D</p> <p>Findings include:</p> <p>During interview on 8/4/26 at 11:23 a.m. R19 stated the Bill of Rights was posted on the first floor but did not recall anyone sitting down and going over the bill of rights.</p> <p>During observation on 8/4/26 at 11:26 a.m. displayed on first floor across from the kitchen door was the RBOR dated 7/1/07.</p> <p>On 8/4/26 at 11:33 a.m. reviewed facility admission packet, the packet included RROB indicated it was revised 11/28/16, modified 2/1/17.</p> <p>ON 8/4/26 at 11:35 a.m. observed a folder in a clear plastic wall hanger, the folder contained RBOR modified 2/1/17.</p> <p>Detailed description of the corrective action taken or planned to correct the deficiency.</p> <p>The updated Resident Bill of Rights was immediately added in all admission packets.</p> <p>All current residents were provided with the updated Resident Bill of Rights.</p> <p>The BOR poster was updated and posted near the main entrance.</p> <p>Address the measures that will be put in place to ensure the deficiency does not reoccur:</p> <p>The facility will conduct quarterly QAPI audits to ensure the Resident Bill of Rights remains current and reflects any required updates.</p> <p>The facility will also continue to monitor and review Minnesota Department of Health and Care Providers</p> |                                              | 09/18/2026                 |

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| F0572<br>SS = D                                              | <p>Continued from page 4</p> <p>ON 8/4/26 at 11:35 a.m. observed a folder in a clear plastic wall hanger, the folder contained RBOR modified 2/1/17.</p> <p>During interview on 8/5/26 at 11:17 a.m. director of nursing (DON) stated the social service director (SSD) worked with marketing and ordered items needed for the admission packets. DON stated they were not aware the RBOR had been updated. DON stated the admission packet surveyors were provided was the most recent packet.</p> <p>During interview on 8/5/26 at 11:22 a.m. SSD stated they personally did not go over RBOR at admission. SSD stated they were not aware of who was responsible for updating the posters for the RBOR, was not aware if residents had been updated regarding the updated RBOR as they had not been aware there was a change.</p> <p>Policy regarding RBOR was requested, however, none was provided.</p>                                                |                                                                  |  | F0572                                                                                                           | <p>Continued from page 4</p> <p>updates for applicable regulatory changes and guidance</p> <p>Identify who is responsible for the corrective actions and monitoring of compliance.</p> <p>Social Services Director, or Designee. Facility Administrator. QAPI Committee.</p> <p>The actual or proposed date for completion of the remedy.</p> <p>09/18/2026</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                              | 09/18/2026                 |
| F0628<br>SS = D                                              | <p>Discharge Process</p> <p>CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)</p> <p>§483.15(c)(2) Documentation.</p> <p>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(iii) Information provided to the receiving provider must include a minimum of the following:</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p> <p>(B) Resident representative information including contact information</p> <p>(C) Advance Directive information</p> <p>(D) All special instructions or precautions for ongoing care, as appropriate.</p> <p>(E) Comprehensive care plan goals;</p> |                                                                  |  | F0628                                                                                                           | <p>F0628 – Discharge Process.</p> <p>SS = D</p> <p>Findings Include:</p> <p>R75's admission Minimum Data Set (MDS) dated 6/22/2026, indicated R75 admitted to the facility 6/11/2026, and had the following diagnoses: anemia, coronary artery disease, diabetes and long-term use of anti-coagulants. R75's medical record identified the following MDS assessments: 1) 6/22/2026 Entry Tracking record 2) 6/22/26 PPS-Discharge Assessment - Return Not Anticipated Review of the May and June Discharge tracking log failed to identify the Ombudsman had been notified of R75's transfer/discharge out of the facility against medical advice. (AMA) Progress note dated 6/11/2026 at 11:11 p.m., indicated R75 admitted to the facility for rehabilitation after a short hospital stay. Progress note dated 6/12/2026 at 2:24 p.m., indicated R75 left the facility AMA at 2:00 p.m. R75's daughter was present and the primary care provider was updated. Progress note dated 6/12/2026 at 3:56 p.m. indicated a MAARC (Minnesota Adult Abuse Reporting Center) report was filed.</p> |                                              | 09/18/2026                 |

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| F0628<br>SS = D                                              | <p>Continued from page 5</p> <p>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.</p> <p>§483.15(c)(3) Notice before transfer.</p> <p>Before a facility transfers or discharges a resident, the facility must-</p> <p>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</p> <p>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> |                                                                  |  | F0628                                                                                                           | <p>Continued from page 5</p> <p>Detailed description of the corrective action taken or planned to correct the deficiency.</p> <p>Transfer/Discharge notice was immediately sent the Office of Ombudsman. A copy was also sent to identified resident and representative via mail.</p> <p>Education provided to all applicable team members on the policy relating to transfers and discharges.</p> <p>Address the measures that will be put in place to ensure the deficiency does not reoccur:</p> <p>Audits for transfers/discharges will occur weekly for three weeks and monthly for two months and audit results will be reviewed at QAPI.</p> <p>Identify who is responsible for the corrective actions and monitoring of compliance.</p> <p>Social Services Director, or Designee. Facility Administrator. QAPI Committee.</p> <p>The actual or proposed date for completion of the remedy.</p> <p>09/18/2026</p> |                                              | 09/18/2026                 |

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| F0628<br>SS = D                                              | <div>Continued from page 6</div> <div>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</div> <div>(i) The reason for transfer or discharge;</div> <div>(ii) The effective date of transfer or discharge;</div> <div>(iii) The location to which the resident is transferred or discharged;</div> <div>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</div> <div>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</div> <div>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</div> <div>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</div> <div>§483.15(c)(6) Changes to the notice.</div> <div>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</div> <div>§483.15(c)(8) Notice in advance of facility closure</div> <div>In the case of facility closure, the individual who is</div> |                                                                     |  | F0628                                                                                                           |                                                                                                                          |                                              | 09/18/2026                 |

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| F0628<br>SS = D                                              | <p>Continued from page 7</p> <p>the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).</p> <p>§483.15(d) Notice of bed-hold policy and return-</p> <p>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-</p> <p>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1 ) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.</p> <p>§483.21(c)(2) Discharge Summary</p> <p>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:</p> <p>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.</p> <p>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to</p> |                                                                  |  | F0628                                                                                                           |                                                                                                                          |                                              | 09/18/2026                 |

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| NAME OF PROVIDER OR SUPPLIER<br><br>ST BENEDICTS CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1810 MINNESOTA BOULEVARD SOUTHEAST , SAINT CLOUD, Minnesota, 56304 |                                                                                                                          |                                              |                            |
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| F0628<br>SS = D                                              | <p>Continued from page 8<br/>authorized persons and agencies, with the consent<br/>of the resident or resident's representative.</p> <p>(iii) Reconciliation of all pre-discharge medications<br/>with the resident's post-discharge medications (both<br/>prescribed and over-the-counter).</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review the facility<br/>failed to notify the Ombudsman of transfers and<br/>discharges for 1 of 2 residents (R75) reviewed for<br/>Ombudsman notification.</p> <p>Findings include:</p> <p>R75's admission Minimum Data Set (MDS) dated<br/>6/22/2026, indicated R75 admitted to the facility<br/>6/11/2026, and had the following diagnoses:<br/>anemia, coronary artery disease, diabetes and<br/>long-term use of anti-coagulants.</p> <p>R75's medical record identified the following MDS<br/>assessments:</p> <p>1) 6/22/2026 Entry Tracking record</p> <p>2) 6/22/26 PPS-Discharge Assessment - Return Not<br/>Anticipated</p> <p>Review of the May and June Discharge tracking log<br/>failed to identify the Ombudsman had been notified<br/>of R75's transfer/discharge out of the facility<br/>against medical advice. (AMA)</p> <p>Progress note dated 6/11/2026 at 11:11 p.m.,<br/>indicated R75 admitted to the facility for<br/>rehabilitation after a short hospital stay. Progress<br/>note dated 6/12/2026 at 2:24 p.m., indicated R75 left<br/>the facility AMA at 2:00 p.m. R75's daughter was<br/>present and the primary care provider was updated.<br/>Progress note dated 6/12/2026 at 3:56 p.m.<br/>indicated a MAARC (Minnesota Adult Abuse<br/>Reporting Center) report was filed.</p> <p>During interview on 8/4/2026 at 1:30 p.m.,<br/>Administrator (Admin) stated the facility did not<br/>routinely report residents who left AMA to the Office<br/>of the Ombudsman. Admin confirmed the<br/>ombudsman wasn't notified when R75 left the<br/>facility. Admin stated it was important to notify the<br/>ombudsman of resident transfers and discharges to</p> |                                                                  |  | F0628                                                                                                           |                                                                                                                          |                                              | 09/18/2026                 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245350 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X3) DATE SURVEY COMPLETED<br><br>08/06/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>ST BENEDICTS CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1810 MINNESOTA BOULEVARD SOUTHEAST , SAINT CLOUD, Minnesota, 56304 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                              |                            |
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| F0628<br>SS = D                                              | Continued from page 9<br>ensure residents were connected to any follow-up<br>services they may need after discharge.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                  |  | F0628                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                              | 09/18/2026                 |
| F0656<br>SS = D                                              | A policy regarding Ombudsman notification was<br>requested but not provided.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                  |  |                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                              |                            |
|                                                              | Develop/Implement Comprehensive Care Plan<br><br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br><br>§483.21(b)(1) The facility must develop and implement<br>a comprehensive person-centered care plan for each<br>resident, consistent with the resident rights set forth<br>at §483.10(c)(2) and §483.10(c)(3), that includes<br>measurable objectives and timeframes to meet a<br>resident's medical, nursing, and mental and<br>psychosocial needs that are identified in the<br>comprehensive assessment. The comprehensive care<br>plan must describe the following -<br><br>(i) The services that are to be furnished to attain or<br>maintain the resident's highest practicable physical,<br>mental, and psychosocial well-being as required<br>under §483.24, §483.25 or §483.40; and<br><br>(ii) Any services that would otherwise be required<br>under §483.24, §483.25 or §483.40 but are not<br>provided due to the resident's exercise of rights<br>under §483.10, including the right to refuse treatment<br>under §483.10(c)(6).<br><br>(iii) Any specialized services or specialized<br>rehabilitative services the nursing facility will provide<br>as a result of PASARR recommendations. If a facility<br>disagrees with the findings of the PASARR, it must<br>indicate its rationale in the resident's medical<br>record.<br><br>(iv)In consultation with the resident and the<br>resident's representative(s)-<br><br>(A) The resident's goals for admission and desired<br>outcomes.<br><br>(B) The resident's preference and potential for future<br>discharge. Facilities must document whether the<br>resident's desire to return to the community was<br>assessed and any referrals to local contact agencies<br>and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan,<br>as appropriate, in accordance with the requirements<br>set forth in paragraph (c) of this section. |                                                                  |  | F0656                                                                                                           | F0656 – Develop/Implement Comprehensive Care<br>Plan<br><br>SS = D<br><br>Findings Include:<br><br>R1's admission minimum data set (MDS) assessment<br>dated 6/8/2026, indicated R1 was cognitively intact,<br>required minimal to moderate assistance with<br>activities of daily living, and had the following<br>diagnoses: acute kidney failure, and renal failure.<br>R1's electronic medical record (EMAR) indicated an<br>order for dialysis every Tuesday, Thursday, and<br>Saturday for hemodialysis. R1's care plan lacked a<br>focus, goal, or intervention specific to R1 receiving<br>dialysis.<br><br>Detailed description of the corrective action taken or<br>planned to correct the deficiency.<br><br>R1 care plan was immediately updated to include a<br>focus, goal, and/or intervention specific to R1<br>receiving dialysis.<br><br>Address the measures that will be put in place to<br>ensure the deficiency does not reoccur:<br><br>Nurse Managers will receive education on developing<br>and maintaining comprehensive, resident-specific<br>care plans, including the need to address dialysis<br>services with an appropriate focus, goal, and<br>interventions. Staff will be instructed to update care<br>plans timely when dialysis is ordered or initiated.<br><br>Audits will be completed weekly for all residents<br>receiving dialysis for three consecutive weeks,<br>followed by monthly audits for two additional<br>months to ensure sustained compliance. Audit<br>results will be reviewed by the QAPI Committee, and<br>any identified deficiencies will be addressed |                                              | 09/18/2026                 |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTIONS         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245350 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                                           |                                                                                                                                                                                                                                                                      | (X3) DATE SURVEY COMPLETED<br><br>08/06/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>ST BENEDICTS CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                     |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1810 MINNESOTA BOULEVARD SOUTHEAST , SAINT CLOUD, Minnesota,<br>56304 |                                                                                                                                                                                                                                                                      |                                              |                            |
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| F0656<br>SS = D                                              | <p>Continued from page 10</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, interviews, and document review, the facility failed to ensure a comprehensive care plan was developed and maintained to include focus, goals, and interventions for dialysis for 1 of 2 residents (R1) who had a diagnosis of kidney failure and was receiving dialysis.</p> <p>Findings include:</p> <p>R1's admission minimum data set (MDS) assessment dated 6/8/2026, indicated R1 was cognitively intact, required minimal to moderate assistance with activities of daily living, and had the following diagnoses: acute kidney failure, and renal failure.</p> <p>R1's electronic medical record (EMAR) indicated an order for dialysis every Tuesday, Thursday, and Saturday for hemodialysis.</p> <p>R1's care plan lacked a focus, goal, or intervention specific to R1 receiving dialysis.</p> <p>During interview on 8/5/2026 at 2:34 p.m., registered nurse (RN-A) stated she was familiar with R1 and confirmed R1 received dialysis 3 days per week. RN-A reviewed R1's care plan and confirmed it did not contain information on R1's nephrologist, where she received dialysis treatments, or how to monitor or care for R1's dialysis site. RN-A stated she would expect to see basic information related to dialysis.</p> <p>During interview on 8/5/2026 at 2:58 p.m., Director of Nursing (DON) stated she was familiar with R1 and that she received dialysis. DON confirmed R1's care plan lacked a focus/goal/intervention for R1's specific dialysis treatment. DON stated she expected care plans for residents receiving dialysis treatments to contain at minimum information specific to each resident such as port or fistula access site, care and monitoring instructions for that site, any specific nutritional guidelines or restrictions and dialysis schedule. DON went on to state it would be important for a care plan to include specific dialysis care instructions to ensure R1 received appropriate care to manage her kidney disease and dialysis treatments.</p> |                                                                     |  | F0656                                                                                                              | <p>Continued from page 10 promptly.</p> <p>Identify who is responsible for the corrective actions and monitoring of compliance.</p> <p>DON, ADON, Nurse Manager, or Designee.</p> <p>The actual or proposed date for completion of the remedy.</p> <p>09/18/2026</p> |                                              | 09/18/2026                 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245350 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X3) DATE SURVEY COMPLETED<br><br>08/06/2026 |                            |
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| F0677<br>SS = D                                              | <p>ADL Care Provided for Dependent Residents</p> <p>CFR(s): 483.24(a)(2)</p> <p>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, record review, and interview, the facility failed to provide assistance with activities of daily living (ADLs) to 1 of 2 residents (R17) reviewed who was dependent on facility staff for cares.</p> <p>Findings include:R17’s Quarterly Minimum Data Set (MDS), dated 05/05/26, indicated the resident was severely cognitively impaired and dependent on staff for activities of daily living. R17’s diagnoses included paraplegia, dementia, anxiety, major depression, and multiple sclerosis.</p> <p>Review of the resident's care plan revealed the resident required assistance with personal hygiene and preferred to be clean shaven.</p> <p>On 08/03/26 at 12:13 p.m., observed R17's face and neck was covered with black and gray whiskers. When asked if having whiskers bothered him, the resident nodded "yes." When asked if he preferred to be shaved every day, the resident again nodded "yes."</p> <p>On 08/04/26 at 11:22 a.m., observed R17 was sleeping in bed with whiskers remaining on his face and neck. Again at 1:21 p.m. R17 continued to have whiskers on his face and neck.</p> <p>On 08/05/26 at 7:55 a.m. observed R17 continued with black and gray whiskers approximately one-half inch long on his face and neck.</p> <p>On 08/05/26 at 11:37 a.m. nursing assistant (NA)-A stated R17 required total assistance with shaving, did not usually refuse shaving, and preferred to be shaved. NA-A stated the resident was not shaved that morning because his electric razor was broken.</p> <p>On 08/05/26 at 11:43 a.m. licensed practical nurse</p> |                                                                  |  | F0677                                                                                                           | <p>F0677 – ADL Care Provided for Dependent Residents</p> <p>SS = D</p> <p>Findings Include:</p> <p>R17’s Quarterly Minimum Data Set (MDS), dated 05/05/26, indicated the resident was severely cognitively impaired and dependent on staff for activities of daily living. R17's diagnoses included paraplegia, dementia, anxiety, major depression, and multiple sclerosis. Review of the resident's care plan revealed the resident required assistance with personal hygiene and preferred to be clean shaven.</p> <p>On 08/03/26 at 12:13 p.m., observed R17's face and neck was covered with black and gray whiskers. When asked if having whiskers bothered him, the resident nodded "yes." When asked if he preferred to be shaved every day, the resident again nodded "yes." On 08/04/26 at 11:22 a.m., observed R17 was sleeping in bed with whiskers remaining on his face and neck. Again at 1:21 p.m. R17 continued to have whiskers on his face and neck. On 08/05/26 at 7:55 a.m. observed R17 continued with black and gray whiskers approximately one-half inch long on his face and neck.</p> <p>Detailed description of the corrective action taken or planned to correct the deficiency.</p> <p>R17 razor was replaced and was immediately shaved.</p> <p>Address the measures that will be put in place to ensure the deficiency does not reoccur:</p> <p>All nursing staff will receive education on providing ADL care in accordance with each resident's care plan and preferences, including shaving and personal hygiene needs.</p> <p>Audits will be completed weekly for all residents care planned to receive shaving services for three consecutive weeks, followed by monthly audits for two additional months to ensure sustained compliance. Audit results will be reviewed by the QAPI Committee, and any identified deficiencies will be addressed promptly.</p> |                                              | 09/18/2026                 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245350 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X3) DATE SURVEY COMPLETED<br><br>08/06/2026 |                            |
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| F0677<br>SS = D                                              | <p>Continued from page 12</p> <p>(LPN)-B stated she had just learned that day the resident's razor was broken and would have to review the documentation.</p> <p>On 08/05/26 at 11:50 a.m. registered nurse (RN)-A stated staff use care guides and the Kardex to identify resident care needs. RN-A stated staff should not document "Not Applicable" when care was refused and had received education regarding proper documentation. RN-A reviewed R17's Kardex and stated the resident preferred to be shaved in the morning and was to be shaved every morning. She further stated she was unaware the razor was broken until that day and would have expected staff to report the equipment issue when it was discovered. After reviewing the documentation, RN-A stated documentation that indicated R17 had been shaved on 08/03/26 did not appear consistent with the observations and would be investigated as possible inaccurate documentation.</p> <p>On 08/05/26 at 12:54 p.m. director of nursing (DON) stated the expectation was that residents be groomed according to their individual preferences. After reviewing R17's care plan DON confirmed R17 preferred to be clean shaven and staff should document the care that was actually provided.</p> <p>Facility Shaving the Resident policy undated, indicated the purpose was to promote cleanliness and to provide skin care. The policy directed staff to review the residents care plan.</p> |                                                                  |  | F0677                                                                                                           | <p>Continued from page 12</p> <p>Identify who is responsible for the corrective actions and monitoring of compliance.</p> <p>DON, ADON, Nurse Manager, or Designee.</p> <p>The actual or proposed date for completion of the remedy.</p> <p>09/18/2026</p>                                                                                                                                                                                                                                                                                                                                                                                              |                                              | 09/18/2026                 |
| F0791<br>SS = D                                              | <p>Routine/Emergency Dental Srvcs in NFs</p> <p>CFR(s): 483.55(b)(1)-(5)</p> <p>§483.55 Dental Services</p> <p>The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>§483.55(b) Nursing Facilities.</p> <p>The facility-</p> <p>§483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident:</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                  |  | F0791                                                                                                           | <p>F0791 – Routine/Emergency Dental Services in NFs</p> <p>SS = D</p> <p>Findings Include:</p> <p>R62's quarterly Minimum Data Set (MDS) dated 7/2/26, indicated R62 had moderate cognitive impairment and required staff assistance with activities of daily living (ADLs). R62's care plan revised 6/25/2, indicated R62 had a self-care deficit related to impaired mobility. R62's care plan further indicated they were usually independent with oral care but needed assistance at times. R62's order summary report printed 8/5/26, indicated R62 received a renal diet, level 7 regular texture diet (kidney friendly with normal textures)</p> |                                              | 09/18/2026                 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245350 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X3) DATE SURVEY COMPLETED<br><br>08/06/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>ST BENEDICTS CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1810 MINNESOTA BOULEVARD SOUTHEAST , SAINT CLOUD, Minnesota, 56304 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                              |                            |
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| F0791<br>SS = D                                              | <p>Continued from page 13</p> <p>(i) Routine dental services (to the extent covered under the State plan); and</p> <p>(ii) Emergency dental services;</p> <p>§483.55(b)(2) Must, if necessary or if requested, assist the resident-</p> <p>(i) In making appointments; and</p> <p>(ii) By arranging for transportation to and from the dental services locations;</p> <p>§483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;</p> <p>§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and</p> <p>§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to provide arrangements for dental care for 1 of 1 resident (R62) reviewed for dental services.</p> <p>Findings include:</p> <p>R62's quarterly Minimum Data Set (MDS) dated 7/2/26, indicated R62 had moderate cognitive impairment and required staff assistance with activities of daily living (ADLs).</p> <p>R62's care plan revised 6/25/2, indicated R62 had a self-care deficit related to impaired mobility. R62's care plan further indicated they were usually independent with oral care but needed assistance at times.</p> |                                                                  |  | F0791                                                                                                           | <p>Continued from page 13</p> <p>During interview on 8/3/26 at 11:46 a.m. R62 stated they had no upper teeth and only a couple of teeth on the bottom, R62 stated they had been wanting dentures but have not gotten any, R62 stated this made eating difficult at times. R62's oral/dental assessment form dated 7/23/25, indicated R62 had no upper teeth/dentures and only two teeth on lower and no dentures. The dental care referral recommendations indicated routine dental referral, R62 had non-urgent dental care needs with note to nursing staff question denture for upper and partial for lower. Review of R62's electronic medical record (EMR) failed to identify follow up was completed regarding the question of upper denture and lower partial dentures.</p> <p>Detailed description of the corrective action taken or planned to correct the deficiency.</p> <p>R62 was immediately offered dental services and was referred to the dental office for evaluation. The resident was seen by the dental provider, and follow-up was completed on the provider's recommendations.</p> <p>Address the measures that will be put in place to ensure the deficiency does not reoccur:</p> <p>All applicable team members will receive education on the importance of timely follow-up and documentation of dental recommendations and referrals.</p> <p>Audits will be completed weekly for three consecutive weeks, followed by monthly audits for two additional months to ensure sustained compliance. Audit results will be reviewed by the QAPI Committee, and any identified deficiencies will be addressed promptly.</p> <p>Identify who is responsible for the corrective actions and monitoring of compliance.</p> <p>Nurse Manager, HUC or Designee.</p> <p>The actual or proposed date for completion of the</p> |                                              | 09/18/2026                 |

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| F0791<br>SS = D                                              | <p>Continued from page 14</p> <p>R62's order summary report printed 8/5/26, indicated R62 received a renal diet, level 7 regular texture diet (kidney friendly with normal textures).</p> <p>During interview on 8/3/26 at 11:46 a.m. R62 stated they had no upper teeth and only a couple of teeth on the bottom, R62 stated they had been wanting dentures but have not gotten any, R62 stated this made eating difficult at times.</p> <p>R62's oral/dental assessment form dated 7/23/25, indicated R62 had no upper teeth/dentures and only two teeth on lower and no dentures. The dental care referral recommendations indicated routine dental referral, R62 had non-urgent dental care needs with note to nursing staff question denture for upper and partial for lower. Review of R62's electronic medical record (EMR) failed to identify follow up was completed regarding the question of upper denture and lower partial dentures.</p> <p>During interview on 8/5/26 at 11:43 a.m. licensed practical nurse (LPN)-B stated they were not aware R62 wanted dentures.</p> <p>During interview on 8/5/26 at 12:12 p.m. registered nurse (RN)-A stated R62 had a screening completed at the facility 7/23/25. RN-A stated R62 was previously seen by an outside dental office but had not been seen there since 2004. RN-A stated they had gone to R62 to ask if they wanted to be seen for dentures and R62 had become tearful and wanted to be seen. RN-A stated that typically dental care was not addressed quarterly during care conferences but believed that was something that should be done to ensure residents dental needs were addressed on a regular basis for comfort, dignity, and basic care.</p> <p>Facility Dental Services policy revised 12/2016, indicated routine and emergency dental services was available to meet the resident's oral health services. The policy further indicated routine and emergency dental services were provided to the residents through a contract agreement with a licensed dentist that came to the facility, a referral to personal dentist, referral to community dentist or referral to other health care organizations that provided dental services.</p> |                                                                  |  | F0791                                                                                                           | <p>Continued from page 14<br/>remedy.</p> <p>09/18/2026</p>                                                              |                                              | 09/18/2026                 |

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| F0880<br>SS = D                                              | <p>Infection Prevention &amp; Control</p> <p>CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control</p> <p>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program.</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must</p> |                                                                  |  | F0880                                                                                                           | <p>F0880 – Infection Prevention &amp; Control</p> <p>SS = D</p> <p>Findings Include:</p> <p>Detailed description of the corrective action taken or planned to correct the deficiency.</p> <p>The LPN was immediately educated on the importance of properly cleaning and disinfecting the glucometer between each resident use to ensure adherence to infection prevention and control practices.</p> <p>Address the measures that will be put in place to ensure the deficiency does not reoccur:</p> <p>All licensed nurses will receive education on proper cleaning and disinfection of glucometers between resident use, in accordance with infection prevention and control practices. Compliance will be reinforced through ongoing monitoring to ensure proper disinfection practices are consistently followed.</p> <p>Audits will be completed weekly for three consecutive weeks, followed by monthly audits for two additional months to ensure sustained compliance. Audit results will be reviewed by the QAPI Committee, and any identified deficiencies will be addressed promptly.</p> <p>Identify who is responsible for the corrective actions and monitoring of compliance.</p> <p>DON, ADON, Nurse Manager, or Designee.</p> <p>The actual or proposed date for completion of the remedy.</p> <p>09/18/2026</p> |                                              | 09/18/2026                 |

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| F0880<br>SS = D                                              | <p>Continued from page 16</p> <p>prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens.</p> <p>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.</p> <p>The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review, the facility failed to ensure the common use blood glucometer machine was disinfected according to current manufacture's recommendation after resident use for 2 of 2 residents (R85, R21) observed for glucometer use, which had the potential to affect all 5 residents (R85, R21, R82, R84, R12) who resided on the transitional care unit and received blood glucose testing in the facility. In addition, the facility failed to review their Infection Prevention And Control Program (IPCP) at least annually, which could affect all 71 residents who resided in the facility.</p> <p>Findings Include:</p> <p>R85's Order Summary Report dated 8/5/26, identified R85 had diagnoses which included type 2 diabetes mellitus (DMII). R85's orders included glucometer (Gluc) checks before meals and at bedtime. R85's orders also included Novolog insulin inject as per sliding scale (insulin order based on current blood glucose level) subcutaneously (under the skin) with meals for DMII.</p> <p>R33's Order Summary Report dated 8/5/26, identified R33 had diagnoses which included DMII. R33's orders included blood sugar checks before meals and at bedtime. R33's orders also included</p> |                                                                  |  | F0880                                                                                                           |                                                                                                                          |                                              | 09/18/2026                 |

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| NAME OF PROVIDER OR SUPPLIER<br><br>ST BENEDICTS CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1810 MINNESOTA BOULEVARD SOUTHEAST , SAINT CLOUD, Minnesota, 56304 |                                                                                                                          |                                              |                            |
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| F0880<br>SS = D                                              | <p>Continued from page 17</p> <p>Free Style Libre 3 Plus Sensor (continuous glucose system sensor) and Novolog insulin, inject 11 unit subcutaneously one time a day before dinner and lunch, and 13 units before breakfast for DMII.</p> <p>R21's Order Summary Report dated 8/5/26, identified R21 had diagnoses which included DMII. R21's orders also included glucose checks before meals and at bedtime. If glucose checks were greater than 300 restart Lantus (insulin) order on HOLD.</p> <p>During observation on 8/3/26 at 3:53 p.m., licensed practical nurse (LPN)-A entered R85's room with a medication cup and a basket with a common use blood glucometer machine and supplies. LPN-A administered R85's pill, then completed a glucometer check for R85. LPN-A placed the glucometer back into the basket, left R85's room then placed the basket on top of the medication cart. LPN-A did not sanitize the glucometer. At 4:03 p.m., LPN-A primed an insulin pen, placed it in the glucometer basket, with the glucometer, then entered R33's room and placed it on the top of the dresser. LPN-A stepped outside of R33's room and applied gown and gloves, then returned to R33's room. LPN-A picked up the basket, placed it on R33's bedside table, administered insulin, then placed R33's insulin pen back into the basket, and placed it on the foot of R33's bed. LPN-A removed the basket from R33's room then returned it to the top of the medication cart. LPN-A removed R33's insulin pen then placed it back into the medication cart drawer. At 4:13 p.m., LPN-A entered R21's room with the glucometer basket and completed a blood glucometer check for R21. LPN-A removed the basket from R21's room and placed the basket back onto the medication cart. LPN-A did not sanitize the glucometer. At 4:16 p.m. LPN-A confirmed she had not sanitized the glucometer after use for R85 or R21. LPN-A indicated she should have sanitized it using the Super Sani-cloths, which were stored on the medication cart. LPN-A indicated her usual practice was to use a Sani-cloth and wipe it all over. When asked if she allowed the glucometer to be kept wet with a cloth, LPN-A indicated she would just wipe it off.</p> <p>The Super Sani-Cloth germicidal disposable wipes label indicated it is a bactericidal, tuberculocidal and virucidal in 2 minutes. Special instructions for cleaning and decontamination against HIV-1, Hepatitis B virus (HBV) and Hepatitis C virus (HCV) of surfaces/objects soiled with blood/body fluids. Cleaning instructions: all blood and other body fluids must be thoroughly cleaned from surfaces and</p> |                                                                  |  | F0880                                                                                                           |                                                                                                                          |                                              | 09/18/2026                 |

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                  |  |                                                                                                                 |                                                                                                                          |                                              |                            |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245350 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                                        |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br>08/06/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>ST BENEDICTS CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1810 MINNESOTA BOULEVARD SOUTHEAST , SAINT CLOUD, Minnesota, 56304 |                                                                                                                          |                                              |                            |
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| F0880<br>SS = D                                              | <p>Continued from page 18</p> <p>objects before disinfection by the germicidal wipe. Open, unfold and use first germicidal wipe to remove heavy soil. Contact time: use second germicidal wipe to thoroughly wet surfaces. Allow: to remain wet two minutes, let air dry.</p> <p>Review of the Assure Platinum glucose monitor by Arkray instruction manual suggested cleaning and disinfecting the meter between patient use. The manual indicated cleaning and disinfecting to be completed by using a commercially available EPA-registered disinfectant detergent or germicide wipe, (list included: Super Sani-Cloth Germicidal Disposable Wipes). The manual further indicated to follow product label instructions to disinfect the meter. The manual indicated if blood was visibly present on the meter two wipes must be used, one wipe to clean and a second wipe to disinfect.</p> <p>During interview on 8/4/26 at 2:02 p.m., registered nurse infection preventionist (IP)-A indicated her expectation was that the common glucometer would be cleaned between each resident, using the Sani-cloths. IP-A stated the glucometer should be wiped off and kept with a cloth on for about two minutes. IP-A indicated this was important to prevent cross contamination and blood born pathogens. IP-A verified the facility had not had any blood born illnesses. IP-A also confirmed the IPCP had not been reviewed annually and stated she had just become the facility IP in January. IP-A verified the last review date on the policy was 12/23.</p> <p>During interview on 8/4/26 at 2:41 p.m., director of nursing (DON) stated her expectation was that the common use glucometer would be cleaned between residents with a disinfectant wipe. DON indicated this was important to make sure clean and would not contaminate a resident. DON stated she was not aware when IPCP was last reviewed but thought it was reviewed as a team. DON verified IPCP policy last review date was 12/23. DON indicated it was important to review the IPCP for any updated changes.</p> <p>The facility policy titled Obtaining A Fingerstick Glucose Level dated 10/11, identified the purpose of the procedure was to obtain a blood sample to determine the resident's blood glucose level. Supplies included a disinfected blood glucose meter (glucometer). Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice.</p> <p>The facility policy titled Cleaning And Disinfection Of</p> |                                                                  |  | F0880                                                                                                           |                                                                                                                          |                                              | 09/18/2026                 |

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                     |  |                                                                                                                 |                                                                                                                          |                                              |                            |
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| NAME OF PROVIDER OR SUPPLIER<br><br>ST BENEDICTS CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                     |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1810 MINNESOTA BOULEVARD SOUTHEAST , SAINT CLOUD, Minnesota, 56304 |                                                                                                                          |                                              |                            |
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| F0880<br>SS = D                                              | Continued from page 19<br>Resident-Care Items And Equipment dated 9/22, identified resident-care equipment, including reusable items and durable medical equipment would be cleaned and disinfected according to current Centers for Disease Control and Prevention (CDC) recommendations for disinfection and the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard. Reusable items were cleaned and disinfected or sterilized between residents. Reusable resident care equipment was decontaminated and/or sterilized between residents according to manufactures instructions. The facility policy titled Infection Prevention And Control Program, dated 12/23, identified the IPCP was established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The policy identified the infection prevention and control committee was responsible for reviewing and providing feedback on the overall program. The infection prevention and control committee, medical director, director of nursing services, and other key clinical and administrative staff would review the infection control policies at least annually. |                                                                     |  | F0880                                                                                                           |                                                                                                                          |                                              | 09/18/2026                 |

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                     |  |                                                                                                                    |                                                                                                                          |                                              |                            |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTIONS         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245350 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILD...<br><br>B. WING                                        |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br>08/04/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>ST BENEDICTS CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                     |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1810 MINNESOTA BOULEVARD SOUTHEAST , SAINT CLOUD, Minnesota,<br>56304 |                                                                                                                          |                                              |                            |
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| K0000<br>Bldg. 01                                            | <p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>An annual Life Safety Code survey was conducted on 08/04/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Saint Benedicts Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.</p> <p>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.</p> <p>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.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.</p> <p>Healthcare Fire Inspections</p> <p>State Fire Marshal Division</p> <p>445 Minnesota St., Suite 145</p> |                                                                     |  | K0000                                                                                                              |                                                                                                                          |                                              | 09/18/2026                 |

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 reverse for further 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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTIONS         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245350 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILD...<br><br>B. WING                                        |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br>08/04/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>ST BENEDICTS CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                     |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1810 MINNESOTA BOULEVARD SOUTHEAST , SAINT CLOUD, Minnesota,<br>56304 |                                                                                                                          |                                              |                            |
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| K0000<br>Bldg. 01                                            | <p>Continued from page 1</p> <p>St. Paul, MN 55101-5145, OR</p> <p>By email to:</p> <p>FM.HC.Inspections@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH<br/>DEFICIENCY MUST INCLUDE ALL OF THE<br/>FOLLOWING INFORMATION:</p> <p>1. A detailed description of the corrective action<br/>taken or planned to correct the deficiency.</p> <p>2. Address the measures that will be put in place to<br/>ensure the deficiency does not reoccur.</p> <p>3. Indicate how the facility plans to monitor future<br/>performance to ensure solutions are sustained.</p> <p>4. Identify who is responsible for the corrective<br/>actions and monitoring of compliance.</p> <p>5. The actual or proposed date for completion of the<br/>remedy.</p> <p>St. Benedicts Care Center is a 5-story building with<br/>a full basement and an Elevator Equipment<br/>Penthouse. The building was constructed at 2<br/>different times. The original building was constructed<br/>in 1978 and was determined to be of Type 1(332)<br/>construction. In 1997, a 2-story addition was added<br/>to the northeast that was determined to be of Type II<br/>(111) construction. Also in 2008, there was a 2-story<br/>addition, with no basement determined to be a Type<br/>II (111). Because the original building and the<br/>additions meet the construction type allowed for<br/>existing buildings, the facility was surveyed as one<br/>building.</p> <p>The building is fully sprinklered throughout. The<br/>facility has a fire alarm system with smoke detection<br/>in the corridors and areas open to the corridors that<br/>is monitored for automatic fire department<br/>notification.</p> |                                                                     |  | K0000                                                                                                              |                                                                                                                          |                                              | 09/18/2026                 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS            |                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245350 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILD...<br><br>B. WING                                     |                                                                                                                                                                                 | (X3) DATE SURVEY COMPLETED<br><br>08/04/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>ST BENEDICTS CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1810 MINNESOTA BOULEVARD SOUTHEAST , SAINT CLOUD, Minnesota, 56304 |                                                                                                                                                                                 |                                              |                            |
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| K0000<br>Bldg. 01                                            | Continued from page 2<br>The facility has a capacity of 75 beds and had a census of 73 at the time of the survey.                                                                                                                                                                                                                                                                                          |                                                                  |  | K0000                                                                                                           |                                                                                                                                                                                 |                                              | 09/18/2026                 |
| K0353<br>SS = E<br>Bldg. 01                                  | The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.                                                                                                                                                                                                                                                                                                                                                   |                                                                  |  | K0353                                                                                                           |                                                                                                                                                                                 |                                              | 09/18/2026                 |
|                                                              | Sprinkler System - Maintenance and Testing                                                                                                                                                                                                                                                                                                                                                                 |                                                                  |  |                                                                                                                 | K0353 – Sprinkler System – Maintenance and Testing                                                                                                                              |                                              |                            |
|                                                              | CFR(s): NFPA 101                                                                                                                                                                                                                                                                                                                                                                                           |                                                                  |  |                                                                                                                 | SS = E                                                                                                                                                                          |                                              |                            |
|                                                              | Sprinkler System - Maintenance and Testing                                                                                                                                                                                                                                                                                                                                                                 |                                                                  |  |                                                                                                                 | Findings include:                                                                                                                                                               |                                              |                            |
|                                                              | Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.                                                                         |                                                                  |  |                                                                                                                 | On 08/04/2026 at 12:28 PM, it was revealed by observation that sprinkler heads above the vending machines on the 1st floor were showing signs of loading with dirt and debris.  |                                              |                            |
|                                                              | a) Date sprinkler system last checked                                                                                                                                                                                                                                                                                                                                                                      |                                                                  |  |                                                                                                                 | On 08/04/2026 at 12:31 PM, it was revealed by observation that sprinkler heads by the flattop grill in the 1st floor Bistro were showing signs of loading with dirt and debris. |                                              |                            |
|                                                              | b) Who provided system test                                                                                                                                                                                                                                                                                                                                                                                |                                                                  |  |                                                                                                                 | On 08/04/2026 at 12:58 PM, it was revealed by observation that sprinkler heads above the dryers in the Main Laundry area were showing signs of loading with dirt and debris.    |                                              |                            |
|                                                              | c) Water system supply source                                                                                                                                                                                                                                                                                                                                                                              |                                                                  |  |                                                                                                                 | Detailed description of the corrective action taken or planned to correct the deficiency                                                                                        |                                              |                            |
|                                                              | Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.                                                                                                                                                                                                                                                                                                     |                                                                  |  |                                                                                                                 | On 08/04/2026, the facility identified sprinkler heads with an accumulation of dirt and debris in the following areas:                                                          |                                              |                            |
|                                                              | 9.7.5, 9.7.7, 9.7.8, and NFPA 25                                                                                                                                                                                                                                                                                                                                                                           |                                                                  |  |                                                                                                                 | Above the vending machines on the 1st floor.                                                                                                                                    |                                              |                            |
|                                                              | This STANDARD is NOT MET as evidenced by:                                                                                                                                                                                                                                                                                                                                                                  |                                                                  |  |                                                                                                                 | Near the flattop grill in the 1st floor Bistro.                                                                                                                                 |                                              |                            |
|                                                              | Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.2(5). These deficient findings could have a patterned impact on residents within the facility. |                                                                  |  |                                                                                                                 | Above the dryers in the Main Laundry area.                                                                                                                                      |                                              |                            |
|                                                              | Findings include:                                                                                                                                                                                                                                                                                                                                                                                          |                                                                  |  |                                                                                                                 | The identified sprinkler heads were immediately cleaned and cleared of dirt and debris to ensure they remained unobstructed and available for proper operation.                 |                                              |                            |
|                                                              | On 08/04/2026 at 12:28 PM, it was revealed by observation that sprinkler heads above the vending machines on the 1st floor were showing signs of loading with dirt and debris.                                                                                                                                                                                                                             |                                                                  |  |                                                                                                                 |                                                                                                                                                                                 |                                              |                            |
|                                                              | On 08/04/2026 at 12:31 PM, it was revealed by observation that sprinkler heads by the flattop grill                                                                                                                                                                                                                                                                                                        |                                                                  |  |                                                                                                                 |                                                                                                                                                                                 |                                              |                            |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTIONS         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245350 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILD...<br><br>B. WING                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X3) DATE SURVEY COMPLETED<br><br>08/04/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>ST BENEDICTS CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                     |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1810 MINNESOTA BOULEVARD SOUTHEAST , SAINT CLOUD, Minnesota, 56304 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                              |                            |
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| K0353<br>SS = E<br>Bldg. 01                                  | <p>Continued from page 3<br/>in the 1st floor Bistro were showing signs of loading<br/>with dirt and debris.</p> <p>On 08/04/2026 at 12:58 PM, it was revealed by<br/>observation that sprinkler heads above the dryers in<br/>the Main Laundry area were showing signs of<br/>loading with dirt and debris.</p> <p>An interview with the Facilities Environmental<br/>Director and Executive Director verified this deficient<br/>finding at the time of discovery.</p> |                                                                     |  | K0353                                                                                                           | <p>Continued from page 3</p> <p>Address the measures that will be put in place to<br/>ensure the deficiency does not reoccur:</p> <p>The EVS Director or designee will educate applicable<br/>team members on maintaining sprinkler heads free<br/>of dirt, debris, and obstructions, including proper<br/>cleaning practices and prompt reporting of any<br/>concerns.</p> <p>Indicate how the facility plans to monitor future<br/>performance to ensure solutions are sustained.</p> <p>A sprinkler head inspection and cleaning process<br/>has been implemented and added into our<br/>computerized maintenance management system.</p> <p>Monthly sprinkler head inspections will be<br/>documented in the computerized maintenance<br/>management system and reviewed by the EVS<br/>Director. Any missed inspections or identified<br/>deficiencies will be addressed and documented<br/>immediately.</p> <p>Identify who is responsible for the corrective actions<br/>and monitoring of compliance.</p> <p>EVS Director, or Designee. Facility Administrator.<br/>QAPI Committee</p> <p>The actual or proposed date for completion of the<br/>remedy.</p> <p>09/18/2026</p> |                                              | 09/18/2026                 |
| K0374<br>SS = E<br>Bldg. 01                                  | <p>Subdivision of Building Spaces - Smoke Barrie</p> <p>CFR(s): NFPA 101</p> <p>Subdivision of Building Spaces - Smoke Barrier<br/>Doors</p> <p>2012 EXISTING</p> <p>Doors in smoke barriers are 1-3/4-inch thick solid<br/>bonded wood-core doors or of construction that<br/>resists fire for 20 minutes. Nonrated protective</p>                                                                                                                                      |                                                                     |  | K0374                                                                                                           | <p>K0374– Subdivision of Building Spaces - Smoke<br/>Barrier Doors</p> <p>SS = E</p> <p>Findings include:</p> <p>On 08/04/2026 at 11:35 AM, it was revealed by<br/>observation that the smoke door leaves on the 3rd</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                              | 09/18/2026                 |

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| NAME OF PROVIDER OR SUPPLIER<br><br>ST BENEDICTS CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1810 MINNESOTA BOULEVARD SOUTHEAST , SAINT CLOUD, Minnesota, 56304 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                              |                            |
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| K0374<br>SS = E<br>Bldg. 01                                  | <p>Continued from page 4</p> <p>plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.</p> <p>19.3.7.6, 19.3.7.8, 19.3.7.9</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to maintain smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.6, 19.3.7.8, and 8.5.4.1. These deficient findings could have a patterned impact on residents within the facility.</p> <p>Findings include:</p> <p>On 08/04/2026 at 11:35 AM, it was revealed by observation that the smoke door leaves on the 3rd floor in Wing 3 had a large gap at the vertical meeting edges that appeared to be greater than 1/8 inch.</p> <p>On 08/04/2026 at 11:57 AM, it was revealed by observation that the smoke door leaves on the 2nd floor in Wing 2 had a large gap at the vertical meeting edges that appeared to be greater than 1/8 inch.</p> <p>On 08/04/2026 at 12:19 PM, it was revealed by observation that the smoke door leaves on the 1st floor in Wing 2 had a large gap at the vertical meeting edges that appeared to be greater than 1/8 inch.</p> <p>An interview with the Facilities Environmental Director and Executive Director verified this deficient finding at the time of discovery.</p> |                                                                  |  | K0374                                                                                                           | <p>Continued from page 4</p> <p>floor in Wing 3 had a large gap at the vertical meeting edges that appeared to be greater than 1/8 inch.</p> <p>On 08/04/2026 at 11:57 AM, it was revealed by observation that the smoke door leaves on the 2nd floor in Wing 2 had a large gap at the vertical meeting edges that appeared to be greater than 1/8 inch.</p> <p>On 08/04/2026 at 12:19 PM, it was revealed by observation that the smoke door leaves on the 1st floor in Wing 2 had a large gap at the vertical meeting edges that appeared to be greater than 1/8 inch.</p> <p>Detailed description of the corrective action taken or planned to correct the deficiency.</p> <p>The following corrections were made to the listed doors.</p> <p>Smoke Door on the 3rd floor on Wing 3</p> <p>Gap was repaired by adding additional door sweeps.</p> <p>Smoke Door on 2nd floor on Wing 2</p> <p>Gap was repaired by adding additional door sweeps.</p> <p>Smoke Door on the 1st floor on Wing 2</p> <p>Gap was repaired by adding additional door sweeps.</p> <p>Address the measures that will be put in place to ensure the deficiency does not reoccur:</p> <p>Monthly smoke door inspections have been added to the computerized maintenance management system to ensure doors close and latch properly without gaps.</p> <p>The EVS Director will educate applicable team</p> |                                              | 09/18/2026                 |

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| K0374<br>SS = E<br>Bldg. 01                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                     |  | K0374                                                                                                           | <div>Continued from page 5<br/>members on proper smoke door inspection and maintenance, with expectations reinforced through team huddles.</div> <div>Indicate how the facility plans to monitor future performance to ensure solutions are sustained.</div> <div>Monthly smoke door inspections will be documented in the computerized maintenance management system and reviewed by the EVS Director.</div> <div>The QAPI Committee will review inspection reports quarterly for compliance. Any missed inspections or identified deficiencies will be addressed and documented immediately.</div> <div>Identify who is responsible for the corrective actions and monitoring of compliance.</div> <div>EVS Director, or Designee. QAPI Committee</div> <div>The actual or proposed date for completion of the remedy.</div> <div>09/18/2026</div> |                                              | 09/18/2026                 |
| K0712<br>SS = E<br>Bldg. 01                                  | <div>Fire Drills</div> <div>CFR(s): NFPA 101</div> <div>Fire Drills</div> <div>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</div> <div>19.7.1.4 through 19.7.1.7</div> <div>This STANDARD is NOT MET as evidenced by:</div> <div>Based on review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code,</div> |                                                                     |  | K0712                                                                                                           | <div>K0712 – Fire Drills</div> <div>SS = E</div> <div>Findings include:</div> <div>On 08/04/2026 at 9:36 AM, it was revealed by review of available documentation that the fire alarm was not activated for fire drills that were conducted on the 2nd shift on 12/12/2025 at 7:30 PM, and 05/06/2026 at 6:30 PM.</div> <div>Detailed description of the corrective action taken or planned to correct the deficiency.</div> <div>Education has been provided to the EVS Supervisor on how and when to conduct fire drills.</div>                                                                                                                                                                                                                                                                                                                    |                                              | 09/18/2026                 |

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| K0712<br>SS = E<br>Bldg. 01                                  | <p>Continued from page 6<br/>section 19.7.1.4. This deficient finding could have a patterned impact on residents within the facility.</p> <p>Findings include: On 08/04/2026 at 9:36 AM, it was revealed by review of available documentation that the fire alarm was not activated for fire drills that were conducted on the 2nd shift on 12/12/2025 at 7:30 PM, and 05/06/2026 at 6:30 PM. An interview with the Facilities Environmental Director and Executive Director verified this deficient finding at the time of discovery.</p>                                              |                                                                  |  | K0712                                                                                                           | <p>Continued from page 6</p> <p>Address the measures that will be put in place to ensure the deficiency does not reoccur:</p> <p>Fire drills have been added to the computerized maintenance management system and are scheduled quarterly on each shift at varying expected and unexpected times and under varying conditions.</p> <p>Indicate how the facility plans to monitor future performance to ensure solutions are sustained.</p> <p>Quarterly fire drills will be documented in the computerized maintenance management system and reviewed by the EVS Director.</p> <p>The QAPI Committee will also review compliance quarterly. Any missed, late, or non-compliant drills will be addressed and documented immediately.</p> <p>Identify who is responsible for the corrective actions and monitoring of compliance.</p> <p>Facility Administrator, EVS Director, QAPI Committee</p> <p>The actual or proposed date for completion of the remedy.</p> <p>09/18/2026</p> |                                              | 09/18/2026                 |
| K0761<br>SS = E<br>Bldg. 01                                  | <p>Maintenance, Inspection &amp; Testing - Doors</p> <p>CFR(s): NFPA 101</p> <p>Maintenance, Inspection &amp; Testing - Doors</p> <p>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.</p> <p>Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.</p> <p>Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.</p> |                                                                  |  | K0761                                                                                                           | <p>K0761 – Maintenance, Inspection &amp; Testing - Doors</p> <p>Findings include:</p> <p>On 08/04/2026 at 11:27 AM, it was revealed by observation that fire doors located between the 3rd floor Dining Room and Wing 1 did not close and latch when released from the magnetic hold-open device.</p> <p>On 08/04/2026 at 11:27 AM, it was revealed by observation that the 3rd floor fire door leading to the east stairwell in Wing 3 did not close and latch when tested.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                              | 09/18/2026                 |

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| K0761<br>SS = E<br>Bldg. 01                                  | <p>Continued from page 7</p> <p>Written records of inspection and testing are maintained and are available for review.</p> <p>19.7.6, 8.3.3.1 (LSC)</p> <p>5.2, 5.2.3 (2010 NFPA 80)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to maintain fire doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, and 4.6.12, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, sections 5.1.5.1, and 5.2.4.2 (6) and (8). These deficient findings could have a patterned impact on residents within the facility.</p> <p>Findings include:</p> <p>On 08/04/2026 at 11:27 AM, it was revealed by observation that smoke/fire doors located between the 3rd floor Dining Room and Wing 1 did not close and latch when released from the magnetic hold-open device.</p> <p>On 08/04/2026 at 11:27 AM, it was revealed by observation that the 3rd floor fire door leading to the east stairwell in Wing 3 did not close and latch when tested.</p> <p>An interview with the Facilities Environmental Director and Executive Director verified this deficient finding at the time of discovery.</p> |                                                                  |  | K0761                                                                                                           | <p>Continued from page 7</p> <p>Detailed description of the corrective action taken or planned to correct the deficiency</p> <p>Smoke/Fire doors located between the third-floor Dining Room and Wing 1 did not close and latch.</p> <p>Door was adjusted and now latching correctly.</p> <p>3rd floor fire door leading to the east stairwell in Wing 3 did not close and latch</p> <p>Door was adjusted and now latching correctly.</p> <p>Address the measures that will be put in place to ensure the deficiency does not reoccur:</p> <p>A task has been established to ensure smoke/fire doors close and latch properly and remain free of gaps or deficiencies.</p> <p>Smoke/fire door audits have also been added to the monthly environmental rounds checklist for ongoing monitoring and compliance.</p> <p>Indicate how the facility plans to monitor future performance to ensure solutions are sustained.</p> <p>Smoke/fire door inspections will be documented in the computerized maintenance management system and reviewed monthly by the EVS Director.</p> <p>Results will also be reviewed quarterly by the QAPI Committee. Any identified deficiencies will be addressed and documented immediately, with follow-up through QAPI until compliance is sustained.</p> <p>Identify who is responsible for the corrective actions and monitoring of compliance.</p> <p>Facility Administrator, EVS Director, QAPI Committee, Safety Committee</p> |                                              | 09/18/2026                 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245350 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILD...<br><br>B. WING                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X3) DATE SURVEY COMPLETED<br><br>08/04/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>ST BENEDICTS CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1810 MINNESOTA BOULEVARD SOUTHEAST , SAINT CLOUD, Minnesota, 56304 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                              |                            |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                  |  | ID<br>PREFIX<br>TAG                                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                              | (X5)<br>COMPLETION<br>DATE |
| K0761<br>SS = E<br>Bldg. 01                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                  |  | K0761                                                                                                           | Continued from page 8                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                              | 09/18/2026                 |
| K0321<br>SS = D<br>Bldg. 01                                  | <p>Hazardous Areas - Enclosure</p> <p>CFR(s): NFPA 101</p> <p>Hazardous Areas - Enclosure</p> <p>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.</p> <p>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.</p> <p>19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms</p> <p>b. Laundries (larger than 100 square feet)</p> <p>c. Repair, Maintenance, and Paint Shops</p> <p>d. Soiled Linen Rooms (exceeding 64 gallons)</p> <p>e. Trash Collection Rooms</p> <p>(exceeding 64 gallons)</p> <p>f. Combustible Storage Rooms/Spaces</p> <p>(over 50 square feet)</p> <p>g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This STANDARD is NOT MET as evidenced by:</p> |                                                                  |  | K0321                                                                                                           | <p>K0321 – Hazardous Areas Enclosure</p> <p>SS = D</p> <p>Findings include:</p> <p>On 08/04/2026 at 11:52 AM, it was revealed by observation that the Clean Utility Room door on the 2nd Floor in Wing 3 did not properly latch when closed using the self-closing device.</p> <p>Detailed description of the corrective action taken or planned to correct the deficiency</p> <p>The following corrections were made to the listed doors.</p> <p>Clean Utility Room door on 2nd Floor in Wing 3,</p> <p>Latch was repaired and door is now latching.</p> <p>Address the measures that will be put in place to ensure the deficiency does not reoccur:</p> <p>Monthly door inspections have been added to the computerized maintenance management system to ensure doors close and latch properly without gaps.</p> <p>The EVS Director will educate applicable team members on proper door inspection and maintenance, with expectations reinforced through team huddles.</p> <p>Indicate how the facility plans to monitor future performance to ensure solutions are sustained.</p> <p>Monthly door inspections will be documented in the</p> |                                              | 09/18/2026                 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245350 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILD...<br><br>B. WING                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br>08/04/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>ST BENEDICTS CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1810 MINNESOTA BOULEVARD SOUTHEAST , SAINT CLOUD, Minnesota, 56304 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                              |                            |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                  |  | ID<br>PREFIX<br>TAG                                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                              | (X5)<br>COMPLETION<br>DATE |
| K0321<br>SS = D<br>Bldg. 01                                  | <p>Continued from page 9</p> <p>Based on observation and staff interview, the facility failed to maintain hazardous area enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 8.7.1.3, and 7.2.1.8. This deficient finding could have an isolated impact on residents within the facility.</p> <p>Findings include: On 08/04/2026 at 11:52 AM, it was revealed by observation that the Clean Utility Room door on the 2nd Floor in Wing 3 did not properly latch when closed using the self-closing device. An interview with the Facilities Environmental Director and Executive Director verified this deficient finding at the time of discovery.</p>                                                                                                                                                                                                                                                                                                                             |                                                                  |  | K0321                                                                                                           | <p>Continued from page 9</p> <p>computerized maintenance management system and reviewed by the Facility Administrator and EVS Director.</p> <p>The QAPI Committee will review inspection reports quarterly for compliance. Any missed inspections or identified deficiencies will be addressed and documented immediately to ensure sustained compliance.</p> <p>Identify who is responsible for the corrective actions and monitoring of compliance.</p> <p>Facility Administrator, EVS Director, QAPI Committee</p> <p>The actual or proposed date for completion of the remedy.</p> <p>09/18/2026</p> |                                              | 09/18/2026                 |
| K0372<br>SS = A<br>Bldg. 01                                  | <p>Subdivision of Building Spaces - Smoke Barrie</p> <p>CFR(s): NFPA 101</p> <p>Subdivision of Building Spaces - Smoke Barrier Construction</p> <p>2012 EXISTING</p> <p>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.</p> <p>19.3.7.3, 8.6.7.1(1)</p> <p>Describe any mechanical smoke control system in REMARKS.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to maintain smoke barrier construction per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, and 8.5.2.1. This deficient finding could have an isolated impact on residents within the facility.</p> <p>Findings include: On 08/04/2026 at 11:15 AM, it</p> |                                                                  |  | K0372                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                              | 08/05/2026                 |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTIONS         |                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245350 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILD...<br><br>B. WING                                     |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br>08/04/2026 |                            |
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| K0372<br>SS = A<br>Bldg. 01                                  | Continued from page 10<br>was revealed by observation that there were ceiling<br>tiles missing from the 4th floor employee restroom.<br>This violation was corrected at the time of discovery.<br>An interview with the Facilities Environmental<br>Director and Executive Director verified this deficient<br>finding at the time of discovery. |                                                                     |  | K0372                                                                                                           |                                                                                                                          |                                              | 08/05/2026                 |