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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 7LEW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00774

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245350**

2.STATE VENDOR OR MEDICAID NO.
(L2) **885740700**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST BENEDICTS SENIOR COMMUNITY**
(L4) **1810 MINNESOTA BOULEVARD SOUTHEAST**
(L5) **SAINT CLOUD, MN** (L6) **56304**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/03/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **198** (L18)

13.Total Certified Beds **198** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
2	196			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, HFE NE II — 06/03/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 06/03/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/15/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/13/2016
(L33)

Posted 06/22/2016 Co.

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245350
June 3, 2016

Ms. Christine Bakke, Administrator
St. Benedict's Senior Community
1810 Minnesota Boulevard Southeast
Saint Cloud, Minnesota 56304

Dear Ms. Bakke:

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

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

Effective May 13, 2016 the above facility is certified for or recommended for:

198 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 198 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 3, 2016

Ms. Christine Bakke, Administrator
St. Benedict's Senior Community
1810 Minnesota Boulevard Southeast
Saint Cloud, Minnesota 56304

RE: Project Number S5350026

Dear Ms. Bakke:

On April 12, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 7, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On June 3, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 16, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 7, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 13, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 7, 2016, effective May 13, 2016 and therefore remedies outlined in our letter to you dated April 12, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245350		6/3/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 05/13/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 05/13/2016	ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 05/13/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** BF/KJ	**DATE** 06/03/2016	**SIGNATURE OF SURVEYOR** 10562	**DATE** 06/03/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 4/7/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245350 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	5/16/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 05/13/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 05/13/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 06/03/2016	SIGNATURE OF SURVEYOR 10562	DATE 05/16/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/5/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245350	A. Building 02 - 2008 ADDITION B. Wing	5/16/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 05/13/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	BF/KJ	06/03/2016	10562	05/16/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/5/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 7LEW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00774

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245350**

2.STATE VENDOR OR MEDICAID NO.
(L2) **885740700**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST BENEDICTS SENIOR COMMUNITY**
(L4) **1810 MINNESOTA BOULEVARD SOUTHEAST**
(L5) **SAINT CLOUD, MN** (L6) **56304**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/07/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **198** (L18)

13.Total Certified Beds **198** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
2	196			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Mardelle Trettel, HFE NE II 04/26/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 05/09/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/15/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 05/12/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 12, 2016

Ms. Christine Bakke, Administrator
St. Benedict's Senior Community
1810 Minnesota Boulevard Southeast
Saint Cloud, Minnesota 56304

RE: Project Number S5350026

Dear Ms. Bakke:

On April 7, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 17, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

by the same deficient practice;

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 7, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal

regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 7, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING _____ B. WING _____	04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assistance was provided with shaving for 1 of 3 residents (R14) reviewed for activities of daily living (ADLs) who were dependent on staff. Findings include: R14's quarterly Minimum Data Set (MDS) dated 2/11/16, identified the resident had severe cognitive impairment, had diagnoses which included dementia, anxiety, and diabetes, and	F 312	The facility objects to the allegations of non-compliance in this statement of deficiency and disagrees with the findings of non-compliance and the level of deficiency cited. The submission of a plan of correction should in no way be considered or construed as agreement with allegations of non-compliance or admission by the facility. 1. Resident R14 had her facial hair removed.	5/13/16

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

Electronically Signed | 04/15/2016

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

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F 312	Continued From page 1 required extensive assistance from staff with all ADLs. On 4/04/16, at 11:54 a.m. during family interview, R14 was observed to have approximately 20 long, coarse, gray chin hairs which measured approximately 1/4" each underneath her chin extending back to the top of her throat. Family Member (FM)-A stated because of R14's severe dementia, the resident is not able to say if it bothers her, however, FM-A stated it bothered her that R14 had long chin hair, and she stated she had noticed facial hair several times in the past year, and thought staff was supposed to be shaving the facial hair off R14. During observation on 4/06/16, at 8:41 a.m. R14 was sitting at the dining room table with 3 other (unidentified) residents. R14 continued to have approximately 20 obvious, long, coarse, gray chin hairs each about 1/4 " in length under her chin to her throat. During observation on 4/07/16, at 1:56 p.m. R14 was laying in bed and continued to have about 20 obvious, long, coarse, gray chin hairs each approximately 1/4" in length underneath her chin to her throat. During interview on 4/07/16, at 1:06 p.m. nursing assistant (NA)-A stated she was not sure if R14 had her own razor, however, if she did not the facility nurse could provide a razor for R14. NA-A stated she had not shaved R14 in the past, and she was not aware of R14 refusing assistance from staff with grooming. NA-A stated R14 should have been offered assistance with shaving every morning with cares.	F 312	2. Re-education on facial hair/grooming has been provided to all nursing staff at the April skills fairs dated 4/12, 4/13, 4/19 and 4/20/2016. The clinical nursing managers and/or their designee will monitor daily grooming on their respective units. 3. Clinical nurse managers will audit facial hair/grooming weekly on all units. 4. The Director of Nursing or their designee will present to the Quality Assurance Committee at the next meeting the audit findings related to grooming and determine the need for periodic auditing.	

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F 312	Continued From page 2 During interview on 4/07/16, at 1:19 p.m. NA-B stated R14's chin hairs should have been removed by staff when assisting the resident with morning cares. NA-B stated she had looked for R14's shaver this morning to shave R14 but couldn't find it, and she should have let the nurse know it was missing so she could have contacted the daughter for a new shaver for R14. NA-B stated the last time she had seen R14's shaver was a couple of weeks ago, however, she had not notified family or nursing staff the shaver was missing. On 4/07/16, at 1:33 p.m. licensed practical nurse (LPN)-A stated she didn't remember the last time R14 had been shaven, and if she would have noticed R14's long chin hairs she would have requested staff assist R14 to shave. LPN-A stated if a residents shaver was missing, she would contact the social worker to work with the family in obtaining a new shaver for the resident. During interview on 4/07/16, at 1:58 p.m. clinical manager (CM)-A stated R14 should have been shaved every morning. CM-A stated when staff could not locate R14's shaver, it should have been reported right away to nursing so they could provide the resident with a new razor. Review of the facility policy titled Cares dated 2/15, indicated the purpose of the policy was to provide procedural guidelines for staff when providing AM and PM cares to residents. The policy directed staff to assist or prompt residents with grooming.	F 312		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		5/13/16

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F 441	Continued From page 3 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441		

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F 441	Continued From page 4 Based on observation, interview, and document review, the facility failed to ensure infection control practices were followed during dining for 2 of 2 residents (R187 and R326) observed during dining services. Findings include: R187's annual Minimum Data Set (MDS) dated 2/19/16, identified R187 had severe cognitive impairment, and required supervision with eating. R326's significant change MDS dated 2/3/16, identified R326 had severe cognitive impairment, and required supervision with eating. During observation on 4/6/16, at 7:31 a.m. nursing assistant (NA)-D was seated between R326 and R187 in a small alcove off of the main dining room at a table for two. NA-D was feeding R326 an orange flavored magic cup (a nutritional supplement) from a Styrofoam cup using a white plastic spoon. After NA-D had fed R326 several bites of the supplement, she set the Styrofoam cup on the table between R326 and R187 and left the area. After NA-D walked away from the table, R187 grabbed the Styrofoam cup with R326's spoon still remaining in the cup, and R187 begun eating R326's supplement from the same container using the same spoon which R326 had just used. When NA-D returned to the table she stated out loud to herself, "Oh my; R187 is eating R326's supplement." NA-D told R187 she would get her a clean spoon, and NA-D returned to the table and traded spoons with R187. R187 continued to eat the supplement with the new spoon, and consumed 100%. During interview on 4/7/16, at 1:06 p.m. NA-A	F 441	The facility objects to the allegations of non-compliance in this statement of deficiency and disagrees with both the finding of non-compliance and the level of deficiency cited. The submission of the plan of correcting should in no way be considered or construed as agreement with allegations of non-compliance or admission by the facility. 1. The ice cream was removed from the table of residents R187 & R326. 2. Re-education on infection control practices during meals was provided by the Infection Preventionist Nurse to staff at the April skills fairs on 4/12, 4/13, 4/19 and 4/20/16. The clinical nurse managers and/or their designee will monitor infection control practices at meal times on their respective units. 3. Clinical nurse managers will audit infection control meal time practices on all nursing units. 4. The Director of Nursing and/or designee will present to the Quality Assurance Committee at the next meeting the audit findings related to mealtime infection control practices and determine the need for periodic auditing.	

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F 441	Continued From page 5 stated if she saw a resident eating another residents food with the same spoon, she would take the food and the spoon away, throw it in the garbage, and get them both something else to eat. NA-A stated both the food and spoon should be taken to prevent cross contamination, and the facility had a recent incident of influenza A and staff were instructed to prevent any type of cross contamination. On 4/7/16, at 1:33 p.m. licensed practical nurse (LPN)-A stated if she saw a resident eat another resident's food, she would take all the food away and start out fresh to prevent the spread of infection and cross contamination. On 4/7/16, at 1:58 p.m. clinical manager (CM)-A stated if staff saw a resident eating another resident's food she would expect staff to remove all the food and replace it. CM-A stated all staff should know their infection control responsibilities, and should have taken the food away and discarded it. Review of the facility policy titled Meal service on the Living Units dated 7/13, indicated residents who require assistance will not have their food until staff is available to assist with eating. The policy further indicated staff would sit with the resident and not get up and leave until the resident was done, or have another staff person take their place.	F 441		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465		5/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 465	Continued From page 6 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure kitchen vents and shelving were clean and free from dust. This had the potential to affect 162 of 162 residents who received food from the kitchen. Findings include: During kitchen observation on 4/4/16, at 8:15 a.m. kitchen hood filters above the steamer, steam kettle, and brazing pan were observed covered with thick dust clumped between the grates and hanging approximately 1/4" (inch) to 1/2" from the vents. Registered Dietetic Technician (DTR)-B stated the particles hanging from the vents and grates were dust, and stated the steamer and steam kettle were used daily to prepare meals for all residents residing in the long term care facility, and the brazing pan was used almost every day. DTR-B stated the vents were to be cleaned by the cooks every other week, however, she was not aware of the last time the vents were cleaned. Upon further observation, the vents above the oven, as well as the top of the oven, were also observed with thick, greasy, black particles and dust. DTR-B stated the ovens were used daily for meal preparation, and the oven tops had been cleaned "about a week ago," and the ovens were on a weekly cleaning schedule. Review of the Cooks Equipment Cleaning Schedule, which was used to track when kitchen equipment was cleaned, dietary staff had	F 465	The facility objects to the allegations of non-compliance in this statement of deficiency and disagrees with both the findings of non-compliance and the level of deficiency cited. The submission of the plan of correction should in no way be considered or construed as agreement with allegations of non-compliance or admission by the facility. 1. The filters and shelving were cleaned immediately. 2. The cleaning schedule was updated and nutrition services staff have been educated on cleaning requirements. 3. Weekly audits have been developed for the shelving and filters and will be completed weekly. Audit results will be presented by the Director of Nutrition Services to the Quality Assurance Committee at the next meeting and determine the need for periodic auditing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 465	Continued From page 7	F 465		

documented the vents above the ovens were last cleaned on 3/26/16.

During a follow up kitchen observation on 4/7/16, at 10:30 a.m. a rolling metal shelving unit with 4 separate shelves had fuzzy dust approximately 1/4" thick hanging from the rungs of the shelf along with multiple white strings hanging down (from cleaning rags stored on the shelf). On the third tier of the metal shelf which had a layer of dust and dried food particles on, there was a steam table pan and a 9" x 9" cooling rack, which were both laying on the shelf and were also coated with dust. Cook -A stated the shelving unit was cleaned weekly, and the white hanging strings were debris from rags. The third shelf also had three large, rubber spatulas sitting on the shelf, and one of the spatulas were being used by Cook-A to scoop out pureed turkey and gravy which was being served for lunch on 4/7/16.

When interviewed on 4/7/16, at 10:55 a.m. Certified Dietary Manager (CDM)-C stated the rolling shelving unit was on the cleaning schedule along with the stove, shelf, and back splash. The Cooks Equipment Cleaning Schedule had been signed off by (unknown) staff which indicated the metal shelving unit had been cleaned the day prior on 4/6/16.

During interview on 4/7/16, at 10:56 a.m., Dietary Aide (DA)-A stated the shelving unit was only cleaned a couple of times a year by maintenance with a power washer.

During interview on 4/7/16, at 11:00 a.m. Cook-B stated the shelving unit was cleaned on a monthly basis using a power washer.

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F 465	Continued From page 8 The Vent Hood Cleaning policy dated 8/12, indicated the purpose was "To ensure a clean and safe environment in which to prepare resident meals." The policy directed staff, "The vent hoods shall be cleaned every other week by cooking staff. The vents shall be removed and cleaned at the same time and cleaned via Hobart Dishwasher. If needed, they will be treated with degreaser prior to washing." The facility policy titled, Sanitation In Nutrition Services dated 8/12, did not specifically address rolling shelving units. The Policy directed staff, "Equipment used will be cleaned and sanitized after each use."	F 465		

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	245350	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department Of Public Safety, State Fire Marshal Division. At the time of this survey, St. Benedicts Senior Community was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:	K 000	EPOC	

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

Electronically Signed | 04/15/2016

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency This facility was surveyed as two buildings: St. Benedicts Senior Community is a 5-story building with a full basement and an Elevator Equipment Penthouse. The building was constructed at 2 different times. The original building was constructed in 1978 and was determined to be of Type 1(332) construction. In 1997, a 2 story addition was added to the northeast that was determined to be of Type II(111) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 197 beds and had a census of 162 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Findings include: During the facility tour it was discovered on 04/05/2016 between 11:30 AM and 4:00 PM: 1. A painted sprinkler head in the Elevator Room. 2. There are multiple sprinkler heads that had dust and debris on them throughout the facility. This deficient practice was confirmed by the Administrator.	K 062	1. The sprinkler head in the elevator room will be replaced. 2. Sprinkler heads throughout the entire building will be inspected and cleaned as needed. Any sprinkler heads unable to be cleaned will be replaced. 3. An inspection and cleaning of all sprinkler heads has been added to our annual fire system inspection process.	5/13/16
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Generators inspected weekly and exercised under load for 30 minutes per month and shall be	K 144	The generator logs have been updated to include documentation of the required	5/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	**1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 3 in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Findings include: During the facility tour and documentation review on 04/05/2016 between 11:30 AM and 4:00 PM, record review revealed the facility did not document the required cool down for the emergency generator. This deficient practice was confirmed by the Administrator.	K 144	cool down period.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING 02 B. WING _____	04/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, St. Benedicts Senior Community 2008 addition was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/15/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING **02 - 2008 ADDITION** B. WING _____	**04/05/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	**1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency St. Benedicts Senior Community Bldg 2 is a 2-story building with no basement. The building was constructed in 2008 and determined to be of Type II(111) construction. The building is fully fie sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, that is monitored for automatic fire department notification. The facility has a capacity of 197 beds and had a census of 162 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)	K 144		5/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING **02 - 2008 ADDITION** B. WING _____	**04/05/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	**1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 2 This STANDARD is not met as evidenced by: Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Findings include: During the facility tour and documentation review on 04/05/2016 between 11:30 AM and 4:00 PM, record review revealed the facility did not document the required cool down for the emergency generator. This deficient practice was confirmed by the Administrator.	K 144	The generator logs have been updated to include the required documentation of the cool down period.	

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
April 12, 2016

Ms. Christine Bakke, Administrator
St. Benedict's Senior Community
1810 Minnesota Boulevard Southeast
Saint Cloud, Minnesota 56304

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5350026

Dear Ms. Bakke:

The above facility was surveyed on April 4, 2016 through April 7, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fischer, Unit Supervisor at (320)223-7338.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)
cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00774	A. BUILDING: _____ B. WING _____	04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00774	A. BUILDING: _____ B. WING _____	04/07/2016

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On April 4th, 5th, 6th, and 7th, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assistance was provided with shaving for 1 of 3 residents (R14) reviewed for activities of daily living (ADLs) who were dependent on staff. Findings include: R14's quarterly Minimum Data Set (MDS) dated 2/11/16, identified the resident had severe cognitive impairment, had diagnoses which included dementia, anxiety, and diabetes, and required extensive assistance from staff with all ADLs. On 4/04/16, at 11:54 a.m. during family interview, R14 was observed to have approximately 20 long, coarse, gray chin hairs which measured approximately 1/4" each underneath her chin extending back to the top of her throat. Family Member (FM)-A stated because of R14's severe	2 920	Corrected	5/13/16

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2 920	Continued From page 3 dementia, the resident is not able to say if it bothers her, however, FM-A stated it bothered her that R14 had long chin hair, and she stated she had noticed facial hair several times in the past year, and thought staff was supposed to be shaving the facial hair off R14. During observation on 4/06/16, at 8:41 a.m. R14 was sitting at the dining room table with 3 other (unidentified) residents. R14 continued to have approximately 20 obvious, long, coarse, gray chin hairs each about 1/4 " in length under her chin to her throat. During observation on 4/07/16, at 1:56 p.m. R14 was laying in bed and continued to have about 20 obvious, long, coarse, gray chin hairs each approximately 1/4" in length underneath her chin to her throat. During interview on 4/07/16, at 1:06 p.m. nursing assistant (NA)-A stated she was not sure if R14 had her own razor, however, if she did not the facility nurse could provide a razor for R14. NA-A stated she had not shaved R14 in the past, and she was not aware of R14 refusing assistance from staff with grooming. NA-A stated R14 should have been offered assistance with shaving every morning with cares. During interview on 4/07/16, at 1:19 p.m. NA-B stated R14's chin hairs should have been removed by staff when assisting the resident with morning cares. NA-B stated she had looked for R14's shaver this morning to shave R14 but couldn't find it, and she should have let the nurse know it was missing so she could have contacted the daughter for a new shaver for R14. NA-B stated the last time she had seen R14's shaver was a couple of weeks ago, however, she had	2 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 920	Continued From page 4 not notified family or nursing staff the shaver was missing. On 4/07/16, at 1:33 p.m. licensed practical nurse (LPN)-A stated she didn't remember the last time R14 had been shaven, and if she would have noticed R14's long chin hairs she would have requested staff assist R14 to shave. LPN-A stated if a residents shaver was missing, she would contact the social worker to work with the family in obtaining a new shaver for the resident. During interview on 4/07/16, at 1:58 p.m. clinical manager (CM)-A stated R14 should have been shaved every morning. CM-A stated when staff could not locate R14's shaver, it should have been reported right away to nursing so they could provide the resident with a new razor. Review of the facility policy titled Cares dated 2/15, indicated the purpose of the policy was to provide procedural guidelines for staff when providing AM and PM cares to residents. The policy directed staff to assist or prompt residents with grooming. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could inservice staff regarding timely and consistent completion of activities of daily living for residents whom are dependent on staff for cares. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control.	21385		5/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21385	Continued From page 5 Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure infection control practices were followed during dining for 2 of 2 residents (R187 and R326) observed during dining services. Findings include: R187's annual Minimum Data Set (MDS) dated 2/19/16, identified R187 had severe cognitive impairment, and required supervision with eating. R326's significant change MDS dated 2/3/16, identified R326 had severe cognitive impairment, and required supervision with eating. During observation on 4/6/16, at 7:31 a.m. nursing assistant (NA)-D was seated between R326 and R187 in a small alcove off of the main dining room at a table for two. NA-D was feeding R326 an orange flavored magic cup (a nutritional supplement) from a Styrofoam cup using a white plastic spoon. After NA-D had fed R326 several bites of the supplement, she set the Styrofoam cup on the table between R326 and R187 and left the area. After NA-D walked away from the table, R187 grabbed the Styrofoam cup with R326's spoon still remaining in the cup, and R187 begun eating R326's supplement from the same container using the same spoon which R326 had just used. When NA-D returned to the table she	21385	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21385	Continued From page 6	21385		

stated out loud to herself, "Oh my; R187 is eating R326's supplement." NA-D told R187 she would get her a clean spoon, and NA-D returned to the table and traded spoons with R187. R187 continued to eat the supplement with the new spoon, and consumed 100%.

During interview on 4/7/16, at 1:06 p.m. NA-A stated if she saw a resident eating another residents food with the same spoon, she would take the food and the spoon away, throw it in the garbage, and get them both something else to eat. NA-A stated both the food and spoon should be taken to prevent cross contamination, and the facility had a recent incident of influenza A and staff were instructed to prevent any type of cross contamination.

On 4/7/16, at 1:33 p.m. licensed practical nurse (LPN)-A stated if she saw a resident eat another resident's food, she would take all the food away and start out fresh to prevent the spread of infection and cross contamination.

On 4/7/16, at 1:58 p.m. clinical manager (CM)-A stated if staff saw a resident eating another resident's food she would expect staff to remove all the food and replace it. CM-A stated all staff should know their infection control responsibilities, and should have taken the food away and discarded it.

Review of the facility policy titled Meal service on the Living Units dated 7/13, indicated residents who require assistance will not have their food until staff is available to assist with eating. The policy further indicated staff would sit with the resident and not get up and leave until the resident was done, or have another staff person take their place.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21385	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure infection control procedures and standards are maintained by all staff as appropriate. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21385		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure kitchen vents and shelving were clean and free from dust. This had the potential to affect 162 of 162 residents who received food from the kitchen. Findings include: During kitchen observation on 4/4/16, at 8:15 a.m. kitchen hood filters above the steamer,	21685	Corrected	5/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00774	A. BUILDING: _____ B. WING _____	04/07/2016

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21685	Continued From page 8	21685		

steam kettle, and brazing pan were observed covered with thick dust clumped between the grates and hanging approximately 1/4" (inch) to 1/2" from the vents. Registered Dietetic Technician (DTR)-B stated the particles hanging from the vents and grates were dust, and stated the steamer and steam kettle were used daily to prepare meals for all residents residing in the long term care facility, and the brazing pan was used almost every day. DTR-B stated the vents were to be cleaned by the cooks every other week, however, she was not aware of the last time the vents were cleaned. Upon further observation, the vents above the oven, as well as the top of the oven, were also observed with thick, greasy, black particles and dust. DTR-B stated the ovens were used daily for meal preparation, and the oven tops had been cleaned "about a week ago," and the ovens were on a weekly cleaning schedule.

Review of the Cooks Equipment Cleaning Schedule, which was used to track when kitchen equipment was cleaned, dietary staff had documented the vents above the ovens were last cleaned on 3/26/16.

During a follow up kitchen observation on 4/7/16, at 10:30 a.m. a rolling metal shelving unit with 4 separate shelves had fuzzy dust approximately 1/4" thick hanging from the rungs of the shelf along with multiple white strings hanging down (from cleaning rags stored on the shelf). On the third tier of the metal shelf which had a layer of dust and dried food particles on, there was a steam table pan and a 9" x 9" cooling rack, which were both laying on the shelf and were also coated with dust. Cook -A stated the shelving unit was cleaned weekly, and the white hanging strings were debris from rags. The third shelf

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21685	Continued From page 9	21685		

also had three large, rubber spatulas sitting on the shelf, and one of the spatulas were being used by Cook-A to scoop out pureed turkey and gravy which was being served for lunch on 4/7/16.

When interviewed on 4/7/16, at 10:55 a.m. Certified Dietary Manager (CDM)-C stated the rolling shelving unit was on the cleaning schedule along with the stove, shelf, and back splash. The Cooks Equipment Cleaning Schedule had been signed off by (unknown) staff which indicated the metal shelving unit had been cleaned the day prior on 4/6/16.

During interview on 4/7/16, at 10:56 a.m., Dietary Aide (DA)-A stated the shelving unit was only cleaned a couple of times a year by maintenance with a power washer.

During interview on 4/7/16, at 11:00 a.m. Cook-B stated the shelving unit was cleaned on a monthly basis using a power washer.

The Vent Hood Cleaning policy dated 8/12, indicated the purpose was "To ensure a clean and safe environment in which to prepare resident meals." The policy directed staff, "The vent hoods shall be cleaned every other week by cooking staff. The vents shall be removed and cleaned at the same time and cleaned via Hobart Dishwasher. If needed, they will be treated with degreaser prior to washing."

The facility policy titled, Sanitation In Nutrition Services dated 8/12, did not specifically address rolling shelving units. The Policy directed staff, "Equipment used will be cleaned and sanitized after each use."

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21685	Continued From page 10 SUGGESTED METHOD OF CORRECTION: The administrator could in-service employees who do cleaning of kitchen ventilation and kitchen equipment on the need to keep equipment clean and sanitary, and do audits to ensure cleaning is completed as scheduled. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21685		