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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BBPD

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 31401

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245633**

2.STATE VENDOR OR MEDICAID NO.
(L2) **639470200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST BENEDICTS SENIOR COMMUNITY**
(L4) **990 19TH STREET SOUTH**
(L5) **SARTELL, MN** (L6) **56377**

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 **01/29/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
**06/30**

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

12.Total Facility Beds **24** (L18)

13.Total Certified Beds **24** (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 |
|---|---|---|---|---|
| | 24 | | | |
| (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, Unit Supervisor 01/30/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 01/30/2018 (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
**10/26/2016**
(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.
**06201**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
**01/30/2018**
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

CMS Certification Number (CCN): 245633 January 30, 2018

Ms. Robin Theis, Administrator
St. Benedicts Senior Community
990 19th Street South
Sartell, MN 56377

Dear Ms. Theis:

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 January 16, 2018, the above facility is recommended for:

24 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 24 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 related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697
St. Paul, MN 55164-0900

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered January 30, 2018

Ms. Robin Theis, Administrator
St. Benedicts Senior Community
990 19th Street South
Sartell, MN 56377

RE: Project Number S5633001

Dear Ms. Theis:

On December 20, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 7, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 29, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 3, 2018 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 December 7, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 16, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 7, 2017, effective January 16, 2018 and therefore remedies outlined in our letter to you dated December 20, 2017, 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 related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** — ID: BBPD

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY** — Facility ID: 31401

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2.STATE VENDOR OR MEDICAID NO.
(L2) **639470200**

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(L3) **ST BENEDICTS SENIOR COMMUNITY**
(L4) **990 19TH STREET SOUTH**
(L5) **SARTELL, MN** (L6) **56377**

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 **12/07/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
**06/30**

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

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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 |
|---|---|---|---|---|
| | **24** | | | |
| (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 :
Michelle Thompson, HFE-NE II — 01/09/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Peterson, Enforcement Specialist — 01/30/2018 (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)

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3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
**10/26/2016**
(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.
**06201**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered December 20, 2017

Ms. Robin Theis, Administrator
St. Benedict's Senior Community
990 19th Street South
Sartell, MN 56377

RE: Project Number S5633001

Dear Ms. Theis:

On December 7, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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 and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fischer@state.mn.us
Phone: (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 January 16, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 16, 2018 the following remedy will be imposed:

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

## 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.

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 March 7, 2018 (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 June 7, 2018 (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 electronic 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
445 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 related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

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 |
|---|---|---|---|
| | 245633 | A. BUILDING _____ B. WING _____ | 12/07/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST BENEDICTS SENIOR COMMUNITY | 990 19TH STREET SOUTH SARTELL, MN 56377 |

| (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 |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 12/05/17, through 12/07/17, during a recertification survey.<br><br>The facility was in full compliance and no deficiencies are issued. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>On 12/05/17 to 12/07/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities.<br><br>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.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 561 SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) | F 561 | | 1/16/18 |

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

Electronically Signed | 12/27/2017

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245633 | A. BUILDING _____ B. WING _____ | 12/07/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST BENEDICTS SENIOR COMMUNITY | 990 19TH STREET SOUTH SARTELL, MN 56377 |

| (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 561 | Continued From page 1<br>(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to help develop a plan to allow safe smoking as desired for 1 of 1 residents (R110) who wanted to smoke while at the facility and was told staff could not assist her.<br><br>Findings include:<br><br>R110's BIMS (Brief Interview Mental Status) 3.0/Delirium - V2 (assessment used to determine cognition) dated 12/1/17, identified R110 had intact cognition with no mental status changes from her baseline. | F 561 | F561 SELF-DETERMINATION<br>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>On 12/6/17, RNCC-B visited with R110 in person and R110's son over the phone to discuss R110's wish to smoke and review risks of smoking while wearing a nicotine patch as well as the need for assistance from family or friends if R110 was not able to get off campus independently. RNCC-B reviewed with R110 that staff would not assist with smoking activities due to being | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245633 | A. BUILDING _____ B. WING _____ | 12/07/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST BENEDICTS SENIOR COMMUNITY | 990 19TH STREET SOUTH SARTELL, MN 56377 |

| (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 561 | Continued From page 2<br>When interviewed on 12/5/17, at 10:10 a.m. R110 stated she would "be happier than punch," if she could smoke while at the facility for rehabilitation. R110 compared her smoking to other people using anxiety pills and stated her smoking had the same "calming" affect for her adding she would rather smoke than start taking medication like others sometimes have to. R110 stated was physically able to smoke without anyone helping her and I "do everything on my own," but had been told she needed family with her as "that's a rule here I guess," and added "which I think is stupid."<br><br>During interview on 12/6/17, at 2:15 p.m. nursing assistant (NA)-A stated R110 was a stand by assist (SBA) with ambulation and spends most of her day inside her room. R110 did, at times, self transfer and walk without staff assistance. Further, NA-A stated R110 had sustained a fall outside while bending over to pick up cigarette butts from the ground, however, added staff were unable to "physically take them [residents]" outside to smoke as it was the facility policy and a non-smoking campus.<br><br>When interviewed on 12/6/17, at 2:31 p.m. R110's family member (FM)-D stated smoking was the "most important thing" to R110 and him having to take her outside to smoke "can be very difficult." FM-D stated the facility provided R110 with a nicotine patch, however, nothing else had been discussed or attempted to allow R110 to smoke as she desired, despite R110 repeatedly expressing desires to continue to smoke while at the facility. FM-D asked one of the nurses about allowing R110 to smoke while at the facility, however, they were told R110 would have to sign out and back in and "[R110] would have to do it | F 561 | a nonsmoking campus but would help with dressing and mobility within facility to help her dress in appropriate outdoor clothing and reach the facility exit safely as well as the need to safely store smoking material and securing them when not in use in R110's lockable bedside drawer or with nursing staff. During RNCC-B's discussion on 12/6/17, R110 declined to smoke that day to be assessed and also denied having smoking material present in her room. R110's son confirmed on 12/6/17 that he had R110's smoking material and would be keeping it for safety; brining it when he visited to assist R110 with smoking. 12/7/17 RN completed smoking assessment with R110 which included family involvement. R110's son did not wish for R110 to be alone outside smoking to which R110 agreed. Smoking assessment deemed R110 appropriate to smoke outside with family for supervision and safety. On 12/7/17, R110's round physician gave orders for patient to utilize nicotine patch and remove one hour before smoking. Patch was also to remain off for one hour after smoking before reapplication. R110 and R110's son were in agreement with this plan and expressed satisfaction with creating a plan that promoted R110's safety while honoring wish to smoke while at facility. A policy originating 02/2016, reviewed annually, reviews that patients are given a copy of the Minnesota and Federal Bill of Rights upon admission informing them of their rights including the right to self-determination and choice. | |

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| F 561 | Continued From page 3<br>on her own."<br><br>When interviewed on 12/6/17, at 4:34 p.m. registered nurse (RN)-A stated residents' who wished to smoke had to do so on their own and without staff assistance as "that's policy here." R110 sustained a fall since she admitted in which she had been outside smoking and fell out of her wheelchair. Since falling, R110 "has asked again" about going out to smoke and other staff have reported to RN-A about her continued desire to smoke, at times, even asking others for cigarettes and offering to pay them for some. RN-A was unaware of any attempts or interventions in place to help R110 smoke while residing at the facility, and added an evaluation to her abilities and desires would be beneficial.<br><br>R110's medical record was reviewed and lacked any evidence the facility had worked with R110 to help develop a plan which would allow her to smoke outside as she desired and had requested.<br><br>On 12/6/17, at 5:16 p.m. registered nurse care coordinator (RNCC)-B and the director of nursing (DON) were interviewed. DON stated if a resident wished to smoke while residing at the facility, the staff "would create a plan with family and friends," to help them do so. RN-B and DON stated they were unaware of R110's desire to continue smoking, and staff should have reported it so a plan to could be developed to allow her to smoke for her "patient centered care," and "quality of life."<br><br>A facility policy on choices was requested, however, none was provided. | F 561 | Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br>All other patients present in facility on 12/7/17 were asked if they utilized tobacco products or had a wish to smoke while at facility. No other patients were identified as having a desire to utilize tobacco products while at facility.<br><br>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:<br>All staff campus wide, will receive education in the form of a communication memo by 1/9/18 reviewing that the facility is a Tobacco Free Campus and need to promote patient centered care and honor patients desires to utilize tobacco products while at facility while promoting safety. The communication will also review safe smoking material storage, the need to report smoking material that is not secure to a nurse, the need for patients who smoke to be assessed for safety, and the facility's smoking policy. Copies of the communication will be sent to each staff member individually as well as posted in employee areas to promote knowledge of information. Nursing staff will complete mandatory education by 1/16/18 which will include the following topics: resident rights | |

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| F 561 | Continued From page 4 | F 561 | and choice, facility smoking policy, smoking material storage, components of a safe and comprehensive smoking plan of care, and competency of material knowledge. Staff who have not completed training by 1/16/18 will be removed from the schedule until completion of education. Nursing staff will audit the smoking preference of each patient, inquiring if each patient utilizes tobacco or has a desire to use tobacco while at facility and create a safe plan if indicated including a smoking assessment if not already completed and appropriate. Social Services or admission paperwork designee will continue to review that the facilitt is a Tobacco Free Campus upon admission and offer nicotine replacement plans or assessment for safe smoking if desired. Self-Determination of Tobacco Use Audits will be completed at least monthly by nursing or designee to ensure compliance. Results of audits will be reported to QAA/QAPI for review and recommendation of ongoing frequency of audits to ensure continued regulation compliance with acknowledgement of patient self-determination and choice. | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent | F 689 | | 1/16/18 |

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| F 689 | Continued From page 5<br>accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to promote safety with smoking for 1 of 1 residents (R110) who was smoking outside the facility.<br><br>Findings include:<br><br>R110's BIMS (Brief Interview Mental Status) 3.0/Delirium - V2 (assessment used to determine cognition) dated 12/1/17, identified R110 had intact cognition with no mental status changes from her baseline.<br><br>On 12/5/17, at 10:12 a.m. R110 was interviewed in her room. R110 stated she recently had sustained a fall while outside smoking as she bent over in her wheelchair to pick up used cigarette butts from the ground. R110 continued to want to smoke while at the facility, however stated she needed family with her as "that's a rule here I guess." R110 showed the surveyor a single cigarette on her bedside table and stated the lighter was "somewhere" in her room adding she would "be happier than punch" if she could go outside and smoke. Further, R110 stated she completed all aspects of smoking (i.e. lighting, ashing, disposing) on her own and needed to physical help from staff or others.<br><br>R110's progress note dated 11/27/17, identified R110 sustained a fall on 11/24/17, when she "was noted to go outside independently to smoke without assistive device." As a result, R110 was started on nicotine replacement therapy. A subsequent progress note dated 11/29/17, | F 689 | F689 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>On 12/6/17, RNCC-B visited with R110 in person and R110's son over the phone to discuss R110's wish to smoke and review risks of smoking while wearing a nicotine patch as well as the need for assistance from family or friends if R110 was not able to get off campus independently. RNCC-B reviewed with R110 that staff would not assist with smoking activities due to being a nonsmoking campus but would help with dressing and mobility within facility to help her dress in appropriate outdoor clothing and reach the facility exit safely as well as the need to safely store smoking material and securing them when not in use in R110's lockable bedside drawer or with nursing staff. During RNCC-B's discussion on 12/6/17, R110 declined to smoke that day to be assessed and also denied having smoking material present in her room. R110's son confirmed on 12/6/17 that he had R110's smoking material and would be keeping it for safety; brining it when he visited to assist R110 with smoking. 12/7/17 RN completed smoking assessment with R110 which included family involvement. R110's son did not wish for R110 to be alone outside smoking to which R110 agreed. Smoking | |

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| F 689 | Continued From page 6<br>identified R110 was using nicotine replacement therapy and had not smoked since her fall. The note added, "If [R110] desires to begin smoking tobacco again, a formal smoking assessment will be completed."<br><br>R110's care plan dated 11/27/17, identified R110 had an alteration in respiratory status related to pneumonia and "smoker status," and listed interventions for staff to provide including administering oxygen, providing medications and, "Nicotine as ordered." The care plan lacked any further information pertaining to R110's smoking.<br><br>When interviewed on 12/6/17, at 2:15 p.m. nursing assistant (NA)-A stated R110 does self transfer and walk on her own, however, was not supposed to for her safety. R110 had sustained a fall while outside smoking recently and obtained a "couple abrasions" as a result. NA-A stated she had never personally observed R110 to go out and smoke on her shift, however, heard from other staff R110 had been attempting to go outside "late at night" to smoke still. NA-A stated residents' who wished to smoke had to go outside on their own according to the policy.<br><br>On 12/6/17, at 2:31 p.m. R110 was wheeled into the building from outside by family member (FM)-D. R110 was dressed in her winter coat and did not have any oxygen on. R110 she was outside having a cigarette. FM-D stated smoking was the "most important thing" for R110 and he was coming to help her smoke outside "every two or three days," since staff at the facility were unable to help her.<br><br>During interview on 12/6/17, at 4:34 p.m. registered nurse (RN)-A stated she had been | F 689 | assessment deemed R110 appropriate to smoke outside with family for supervision and safety. On 12/7/17, R110's round physician gave orders for patient to utilize nicotine patch and remove one hour before smoking. Patch was also to remain off for one hour after smoking before reapplication. R110 and R110's son were in agreement with this plan and expressed satisfaction with creating a plan that promoted R110's safety while honoring wish to smoke while at facility. A policy originating 02/2016, reviewed annually, reviews that patients are given a copy of the Minnesota and Federal Bill of Rights upon admission informing them of their rights including the right to self-determination and choice.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br>All other patients present in facility on 12/7/17 were asked if they utilized tobacco products or had a wish to smoke while at facility. No other patients were identified as having a desire to utilize tobacco products while at facility.<br><br>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:<br>All staff campus wide, will receive | |

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| F 689 | Continued From page 7<br>working the night R110 fell while outside smoking. R110 had gone outside without staff consent or knowledge, and fell while trying to pick up a cigarette butt off the ground sustaining some abrasions and a small cut from the fall. RN-A was unaware if R110 had been outside to smoke, again, since falling on 11/24/17, nor if family was taking her outside to smoke. RN-A stated R110 had "asked again" since falling about going outside to smoke including even asking staff to provide cigarettes to her. RN-A stated she had seen cigarettes in R110's room, most recently "this past Sunday [12/3/17]," however, had not been assessed for her smoking, either supervised or unsupervised, to her knowledge. RN-A stated assessing R110's smoking abilities would be beneficial "just for her [R110] to be safe out there."<br><br>R110's medical record was reviewed and lacked any evidence R110 had been comprehensively assessed for safety with smoking despite still going outside to smoke with family; having sustained a fall while smoking unsupervised; and having cigarettes/lighter(s) on her person.<br><br>On 12/6/17, at 5:16 p.m. registered nurse care coordinator (RNCC)-B and the director of nursing (DON) were interviewed. R110 was placed on a nicotine patch after falling while outside smoking unsupervised, however, had not been assessed as they thought the nicotine patch was working and going well for R110. Further, DON and RNCC-B were unaware floor staff had found R110 with cigarettes in her room before, and they would "create a safe plan" so R110 could smoke safely going forward.<br><br>A facility Smoking Assessment - Long Term Care | F 689 | education in the form of a communication memo by 1/9/18 reviewing that the facility is a Tobacco Free Campus and need to promote patient centered care and honor patients desires to utilize tobacco products while at facility while promoting safety. The communication will also review safe smoking material storage, the need to report smoking material that is not secure to a nurse, the need for patients who smoke to be assessed for safety, and the facility's smoking policy. Copies of the communication will be sent to each staff member individually as well as posted in employee areas to promote knowledge of information. Nursing staff will complete mandatory education by 1/16/18 which will include the following topics: resident rights and choice, facility smoking policy, smoking material storage, components of a safe and comprehensive smoking plan of care, and competency of material knowledge. Staff who have not completed training by 1/16/18 will be removed from the schedule until completion of education. Nursing staff will audit the smoking preference of each patient, inquiring if each patient utilizes tobacco or has a desire to use tobacco while at facility and create a safe plan if indicated including a smoking assessment if not already completed and appropriate. Observation of unsecured smoking material was added to the safety audit conducted monthly by a member of the safety committee. Social Services or admission paperwork designee will continue to review that the facility is a Tobacco Free Campus upon admission | |

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| F 689 | Continued From page 8<br>policy dated 11/17, identified residents who wished to smoke "need to smoke safely," and listed all residents who choose to smoke "are evaluated and assessed for smoking safety." | F 689 | and offer nicotine replacement plans or assessment for safe smoking if desired. Safety Audits will be completed at least monthly to observe for unsecure smoking material by nursing or designee to ensure compliance. Results of audits will be reported to QAA/QAPI for review and recommendation of ongoing frequency of audits to ensure continued regulation compliance with prevention of accidents and hazards. | |
| F 726 SS=D | Competent Nursing Staff<br>CFR(s): 483.35(a)(3)(4)(c)<br><br>§483.35 Nursing Services<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. | F 726 | | 1/16/18 |

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| F 726 | Continued From page 9<br>§483.35(c) Proficiency of nurse aides.<br>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to ensure nurses were trained to administer insulin from a pen for 1 of 1 residents (R113) observed to receive insulin from a pen.<br><br>Findings include:<br><br>R113's physician orders signed 11/25/17, directed staff to administer subcutaneous via pen, Humlin R U-500 (insulin used to control blood sugar) 75 units at breakfast, 40 units at lunch and 75 units at dinner.<br><br>During interview on 12/5/17, at 8:49 a.m. licensed practical nurse (LPN)-A stated the licensed nurses worked twelve hours shifts which helped with continuity of care.<br><br>During observation on 12/6/17, at 5:15 p.m. registered nurse (RN)-C used an alcohol wipe to cleanse the end of the insulin pen, then attached the needle. RN-C then dialed the insulin pen to 75 units and administered the dose in R113's left abdomen. RN-C did not prime the insulin pen with 5 units prior to dialing and administrating the 75 units of insulin.<br><br>During interview on 12/6/17, at 5:55 p.m. RN-C stated she did not prime the insulin pen prior to administrating the ordered dose as the pen had | F 726 | F726 COMPETENT NURSING STAFF<br>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>On the evening of 12/6/17 and morning of 12/7/17, DON met 1:1 with each nurse on duty to review expectation of priming insulin pen prior to administration to which all nurses acknowledged prior knowledge of. On 12/7/17, a prompt was added to the EMAR as a stop point for nurses to acknowledge the need to prime the insulin pen prior to every insulin administration.<br>Review of rounding physician progress notes, notes documentation of blood glucose level reviews on 11/26/17, 11/28/17, 12/1/17, 12/4/17, and 12/8/17. 12/8/17 notes rounding physician to state, “blood sugars show excellent control.” Rounding physician continued to follow blood glucose levels through R113’s discharge on 12/15/17.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br>A review of medication serves and physician’s orders on all other patients on 12/7/17 did not note any other insulin pens to be utilized in facility. | |

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| F 726 | Continued From page 10<br>been continuously used and was not a new pen.<br><br>R113's December 2017 medication administration record identified R113's blood sugar levels were checked four times daily. R113's blood sugars at 7:30 a.m. ranged from 92 to 140; at 11:30 a.m. blood sugars ranged from 204- 325; 5:00 p.m. blood sugars ranged from 123- 276 and 9:30 p.m. blood sugars ranged from 102- 221. R113's blood sugars did not indicate notification to the physician.<br><br>Review of RN-C's St. Benedict's Senior Community General Orientation dated 11/7/17, indicated RN-C had a skill/ competency review on subcutaneous injections; however, it did not include administration of insulin via pen and only included RN-C's initials indicating she was competent. There was no documentation to demonstrate RN-C's competency for the use of insulin pens.<br><br>During interview on 12/7/17, at 11:15 a.m. director of nursing (DON) stated her expectation was the staff prime the insulin pen each time it was used because the needle is exchanged after each injection. If the insulin pen was not primed before administrating the ordered dose the resident could be given less or more of the required dose and could include air within the injection. Further, DON stated RN-C had been hired within the last 30 days and the facility had not initiated new competency training at the time for new staff. To the DON's knowledge there was not any training on insulin pens specifically, as the facility rarely administered insulin from pens. The DON expected nurses to ask for education if they were not familiar with administrating insulin from pens. Further, DON stated the facility currently | F 726 | 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:<br>Licensed nursing staff will complete mandatory education by 1/16/18 reviewing facility's insulin administration policy, appropriate insulin administration using multi-dose vials and pens, and skills knowledge testing via insulin pen administration and multi-dose vial insulin administration competencies. Staff who have not completed training by 1/16/18 will be removed from the schedule until completion of education. DON or designee will audit 10% of insulin pen administration with each patient utilizing pens monthly due to the limited use of insulin pens at facility. Annual skills fair will continue to include insulin administration via multi-dose vials and insulin pens. Insulin Administration Audits will be completed with each patient utilizing Insulin pens to observe for errors in administration. Results of audits will be reported to QAA/QAPI for review and recommendation of ongoing frequency of audits to ensure continued regulation compliance with competent nursing staff and error prevention. | |

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| F 726 | Continued From page 11 | F 726 | | |

practiced "on the spot" training when needed for the nurses as well as skills fairs. Although, the competency tests had been created insulin pens, the skills days had not occurred to date (12/7/17).

During interview on 12/7/17, at 11:34 a.m. RN- D stated insulin pens needed to be primed before administrating the dose as ordered. RN-D stated insulin pen priming was taught when she attended nursing school as well as at a skills fair that summer.

When interviewed on 12/7/17, at 11:35 a.m. RN-E stated insulin pens needed to be primed before administrating the dose as ordered and remembered attending a skills fair that summer.

Although, RN-D was observed to not prime the insulin pen according to manufacturers recommendations, the facility had not initiated their competency testing program to ensure all licensed staff knew how to correctly administer insulin using the insulin pens. The facility nurses work twelve our shifts, which places residents at an increased risk of inaccurate management of their diabetes when nurses have not completed competencies in this area.

Humulin R U- 500 package insert dated 12/29/15, directed to prime the pen before each injection with 5 units. "If you do not prime before each injection, you may get too much or too little insulin."

The Facility Assessment Tool dated 11/27/17, directed competency training would include "medication administration- injectable, oral, subcutaneous, topical."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245633 | A. BUILDING _____ B. WING _____ | 12/07/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST BENEDICTS SENIOR COMMUNITY | 990 19TH STREET SOUTH SARTELL, MN 56377 |

| (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 |
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| F 755 | Continued From page 12 | F 755 | | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to ensure an insulin pens was primed prior to dosing and administration of | F 755 | F755 PHARMACY SERVICIES/PHARMACISTS/RECORDS<br>Address how corrective action will be | 1/16/18 |

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| F 755 | Continued From page 13<br>insulin for 1 of 1 residents (R113) who utilized an insulin pen in the facility.<br><br>Findings include:<br><br>R113's BIMS (Brief Interview Mental Status) 3.0/Delirium - V 2 (assessment used to determine cognition) dated 12/1/17, identified R113 had intact cognition with no mental status changes from her baseline. R113's undated Admission Record identified a diagnosis of type 2 diabetes mellitus.<br><br>R113's physician orders signed 11/25/17, directed staff to administer subcutaneous via pen, Humlin R U-500 (insulin used to control blood sugar) 75 units at breakfast, 40 units at lunch and 75 units at dinner.<br><br>During observation on 12/6/17, at 5:15 p.m. registered nurse (RN)-C used an alcohol wipe to cleanse the end of the insulin pen, then attached the needle. RN-C then dialed the insulin pen to 75 units and administered the dose in R113's left abdomen. RN-C did not prime the insulin pen with 5 units prior to dialing and administrating the 75 units of insulin.<br><br>During interview on 12/6/17, at 5:55 p.m. RN-C stated she did not prime the insulin pen prior to administrating the ordered dose as the pen had been continuously used and was not a new pen.<br><br>R113's December 2017 medication administration record identified R113's blood sugar levels were checked four times daily. R113's blood sugars at 7:30 a.m. ranged from 92 to 140. R113's 11:30 a.m. blood sugars ranged from 204- 325. R113' 5:00 p.m. blood sugars ranged from 123- 276. | F 755 | accomplished for those residents found to have been affected by the deficient practice:<br>On the evening of 12/6/17 and morning of 12/7/17, DON met 1:1 with each nurse on duty to review expectation of priming insulin pen prior to administration to which all nurses acknowledged prior knowledge of. On 12/7/17, a prompt was added to the EMAR as a stop point for nurses to acknowledge the need to prime the insulin pen prior to every administration. Review of rounding physician progress notes, notes documentation of blood glucose levels reviews on 11/26/17, 11/28/17, 12/1/17, 12/4/17, and 12/8/17. 12/8/17 notes rounding physician to state, “blood sugars show excellent control.” Rounding physician continued to follow blood glucose levels through R113’s discharge on 12/15/17.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:<br>A review of medication serves and physician’s orders on all other patients on 12/7/17 did not note any other insulin pens to be utilized in facility.<br><br>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: | |

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| ST BENEDICTS SENIOR COMMUNITY | 990 19TH STREET SOUTH SARTELL, MN 56377 |

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| F 755 | Continued From page 14<br>R113's 9:30 p.m. blood sugars ranged from 102-221. R113's blood sugars did not indicate notification to the physician.<br><br>During interview on 12/7/17, at 11:15 a.m. director of nursing (DON) stated her expectation was that staff prime the insulin pen each time it was used because the needle is exchanged after each injection. If the insulin pen was not primed before administrating the ordered dose the resident could be given less or more of the required dose and could include air within the injection.<br><br>The facility policy insulin Administration dated 2/17, did not include administration of insulin from an insulin pen.<br><br>Humulin R U- 500 package insert dated 12/29/15, directed to prime the pen before each injection with 5 units. "If you do not prime before each injection, you may get too much or too little insulin." | F 755 | Licensed nursing staff will complete mandatory education by 1/16/18 reviewing facility's insulin administration policy, appropriate insulin administration using multi-dose vials and pens, and skills knowledge testing via insulin pen administration and multi-dose vial insulin administration competencies. Staff who have not completed training by 1/16/18 will be removed from the schedule until completion of education. DON or designee will audit 10% of insulin pen administration with each patient utilizing pens monthly due to the limited use of insulin pens at facility. Annual skills fair will continue to include insulin administration via multi-dose vials and insulin pens. Insulin Administration Audits will be completed with each patient utilizing Insulin pens to observe for errors in administration. Results of audits will be reported to QAA/QAPI for review and recommendation of ongoing frequency of audits to ensure continued regulation compliance with competent nursing staff and error prevention. | |

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| | 245633 | A. BUILDING **01 - ST BENEDICTS SENIOR COMMUNITY SARTELL** B. WING _____ | **12/05/2017** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>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.<br><br>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.<br><br>A an initial Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on December 05, 2017. At the time of this survey, St. Benedict's Senior Community Therapy Suites 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES<br>( K-TAGS) TO:<br><br>Health Care Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145 | K 000 | EPOC | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 12/27/2017 |

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<br>St Paul, MN 55101-5145, or<br><br>By email to:<br>Marian.Whitney@state.mn.us and<br>Angela.Kappenman@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br>St. Benedict's Senior Community Therapy Suites is a 1-story building with a full basement built of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and resident rooms and is monitored by a central monitoring company. It is protected by a full automatic sprinkler system with supervision by the fire alarm. The facility has a capacity of 24 beds and had a census of 20 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by. | K 000 | | |
| K 324 SS=F | Cooking Facilities<br>CFR(s): NFPA 101<br><br>Cooking Facilities<br>Cooking equipment is protected in accordance | K 324 | | 12/5/17 |

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|---|---|---|---|---|
| K 324 | Continued From page 2<br>with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of documentation and an interview with staff, it was determined that the kitchen hood suppression system is not in accordance with NFPA 101 The Life Safety Code (edition 2012), Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke | K 324 | The griddle and cooking spray were removed immediately from the kitchen when identified. The Director of Dining Services or designee will ensure compliance by conducting random weekly audits through April of 2018. | |

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| K 324 | Continued From page 3<br>compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2<br><br>Findings Include:<br><br>At approximately 0930, on 12/05/2017, observations and interview by a team member of the Health Department revealed, the facility has a neighborhood kitchen with a steam table and was found to be cooking eggs on a griddle. When the dietary manager was interviewed it was discovered that Eggs and Bacon are cooked on a daily basis. The griddle and cooking spray was removed from the facility immediately upon Deputy State Fire Marshal's arrival.<br><br>This deficient practice was confirmed by the Director of Maintenance at the time of discovery. | K 324 | | |
| K 712 SS=F | Fire Drills<br>CFR(s): NFPA 101<br><br>Fire Drills<br>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at 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 | K 712 | | 12/5/17 |

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| | 245633 | A. BUILDING **01 - ST BENEDICTS SENIOR COMMUNITY SARTELL** B. WING _____ | **12/05/2017** |

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| K 712 | Continued From page 4<br>routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.<br>18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility failed to provide documentation of fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all residents and an undetermined amount of staff and visitors.<br><br>Findings include:<br><br>During the facility documentation review on 12/05/2017, documentation reviewed revealed that Fire drills were not performed or incomplete during these times:<br><br>1) First shift of the first quarter.<br>2) Third shift of the second quarter.<br>3) Second shift of the quarter.<br><br>This deficient condition was confirmed by the Director of Maintenance . | K 712 | Fire drills were conducted on each shift quarterly based on facility opening date versus calendar year. The Director of Maintenance created a new spread sheet based on calendar year that scheduled 2018 fire drills ensuring that drills will be conducted quarterly for each shift. The new spread sheet was approved by the Fire Marshal during survey. | |

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered December 20, 2017

Ms. Robin Theis, Administrator
St. Benedict's Senior Community
990 19th Street South
Sartell, MN 56377

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5633001

Dear Ms. Theis:

The above facility was surveyed on December 5, 2017 through December 7, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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 Unit Supervisor Brenda Fischer at brenda.fischer@state.mn.us or (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 related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206  Fax #: 651-215-9697

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 |
|---|---|---|---|
| | 31401 | A. BUILDING: _____ B. WING _____ | 12/07/2017 |

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| ST BENEDICTS SENIOR COMMUNITY | 990 19TH STREET SOUTH SARTELL, MN 56377 |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health (MDH) 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 | | |

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| ST BENEDICTS SENIOR COMMUNITY | 990 19TH STREET SOUTH SARTELL, MN 56377 |

| (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 |
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| 2 000 | Continued From page 1<br><br>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.<br><br>On 12/05/17 to 12/07/17, 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.<br><br>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. | 2 000 | | |

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| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to promote safety with smoking for 1 of 1 residents (R110) who was smoking outside the facility.<br><br>Findings include:<br><br>R110's BIMS (Brief Interview Mental Status) 3.0/Delirium - V2 (assessment used to determine cognition) dated 12/1/17, identified R110 had intact cognition with no mental status changes from her baseline.<br><br>On 12/5/17, at 10:12 a.m. R110 was interviewed in her room. R110 stated she recently had sustained a fall while outside smoking as she bent over in her wheelchair to pick up used cigarette butts from the ground. R110 continued to want to smoke while at the facility, however | 2 830 | corrected | 12/7/17 |

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| 2 830 | Continued From page 3 | 2 830 | | |

stated she needed family with her as "that's a rule here I guess." R110 showed the surveyor a single cigarette on her bedside table and stated the lighter was "somewhere" in her room adding she would "be happier than punch" if she could go outside and smoke. Further, R110 stated she completed all aspects of smoking (i.e. lighting, ashing, disposing) on her own and needed to physical help from staff or others.

R110's progress note dated 11/27/17, identified R110 sustained a fall on 11/24/17, when she "was noted to go outside independently to smoke without assistive device." As a result, R110 was started on nicotine replacement therapy. A subsequent progress note dated 11/29/17, identified R110 was using nicotine replacement therapy and had not smoked since her fall. The note added, "If [R110] desires to begin smoking tobacco again, a formal smoking assessment will be completed."

R110's care plan dated 11/27/17, identified R110 had an alteration in respiratory status related to pneumonia and "smoker status," and listed interventions for staff to provide including administering oxygen, providing medications and, "Nicotine as ordered." The care plan lacked any further information pertaining to R110's smoking.

When interviewed on 12/6/17, at 2:15 p.m. nursing assistant (NA)-A stated R110 does self transfer and walk on her own, however, was not supposed to for her safety. R110 had sustained a fall while outside smoking recently and obtained a "couple abrasions" as a result. NA-A stated she had never personally observed R110 to go out and smoke on her shift, however, heard from other staff R110 had been attempting to go outside "late at night" to smoke still. NA-A stated

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| 2 830 | Continued From page 4<br>residents' who wished to smoke had to go outside on their own according to the policy.<br><br>On 12/6/17, at 2:31 p.m. R110 was wheeled into the building from outside by family member (FM)-D. R110 was dressed in her winter coat and did not have any oxygen on. R110 she was outside having a cigarette. FM-D stated smoking was the "most important thing" for R110 and he was coming to help her smoke outside "every two or three days," since staff at the facility were unable to help her.<br><br>During interview on 12/6/17, at 4:34 p.m. registered nurse (RN)-A stated she had been working the night R110 fell while outside smoking. R110 had gone outside without staff consent or knowledge, and fell while trying to pick up a cigarette butt off the ground sustaining some abrasions and a small cut from the fall. RN-A was unaware if R110 had been outside to smoke, again, since falling on 11/24/17, nor if family was taking her outside to smoke. RN-A stated R110 had "asked again" since falling about going outside to smoke including even asking staff to provide cigarettes to her. RN-A stated she had seen cigarettes in R110's room, most recently "this past Sunday [12/3/17]," however, had not been assessed for her smoking, either supervised or unsupervised, to her knowledge. RN-A stated assessing R110's smoking abilities would be beneficial "just for her [R110] to be safe out there."<br><br>R110's medical record was reviewed and lacked any evidence R110 had been comprehensively assessed for safety with smoking despite still going outside to smoke with family; having sustained a fall while smoking unsupervised; and having cigarettes/lighter(s) on her person. | 2 830 | | |

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| 2 830 | Continued From page 5<br><br>On 12/6/17, at 5:16 p.m. registered nurse care coordinator (RNCC)-B and the director of nursing (DON) were interviewed. R110 was placed on a nicotine patch after falling while outside smoking unsupervised, however, had not been assessed as they thought the nicotine patch was working and going well for R110. Further, DON and RNCC-B were unaware floor staff had found R110 with cigarettes in her room before, and they would "create a safe plan" so R110 could smoke safely going forward.<br><br>A facility Smoking Assessment - Long Term Care policy dated 11/17, identified residents who wished to smoke "need to smoke safely," and listed all residents who choose to smoke "are evaluated and assessed for smoking safety."<br><br>SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee, could provide education to nursing staff about the importance of ensuring assessment is conducted and plans of care followed to ensure residents receive care and supervision in a safe manner related to smoking. The DON or designee, could randomly audit to be sure the proper nursing supervision is provided the residents.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |
| 21525 | MN Rule 4658.1305 A.B.C Pharmacist Service Consultation<br><br>A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who: | 21525 | | 12/7/17 |

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| 21525 | Continued From page 6<br>A. provides consultation on all aspects of the provision of pharmacy services in the nursing home;<br>B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br>C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to ensure an insulin pens was primed prior to dosing and administration of insulin for 1 of 1 residents (R113) who utilized an insulin pen in the facility.<br><br>Findings include:<br><br>R113's BIMS (Brief Interview Mental Status) 3.0/Delirium - V 2 (assessment used to determine cognition) dated 12/1/17, identified R113 had intact cognition with no mental status changes from her baseline. R113's undated Admission Record identified a diagnosis of type 2 diabetes mellitus.<br><br>R113's physician orders signed 11/25/17, directed staff to administer subcutaneous via pen, Humlin R U-500 (insulin used to control blood sugar) 75 units at breakfast, 40 units at lunch and 75 units at dinner.<br><br>During observation on 12/6/17, at 5:15 p.m. registered nurse (RN)-C used an alcohol wipe to cleanse the end of the insulin pen, then attached the needle. RN-C then dialed the insulin pen to 75 units and administered the dose in R113's left | 21525 | Corrected | |

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| 21525 | Continued From page 7<br>abdomen. RN-C did not prime the insulin pen with 5 units prior to dialing and administrating the 75 units of insulin.<br><br>During interview on 12/6/17, at 5:55 p.m. RN-C stated she did not prime the insulin pen prior to administrating the ordered dose as the pen had been continuously used and was not a new pen.<br><br>R113's December 2017 medication administration record identified R113's blood sugar levels were checked four times daily. R113's blood sugars at 7:30 a.m. ranged from 92 to 140. R113's 11:30 a.m. blood sugars ranged from 204- 325. R113' 5:00 p.m. blood sugars ranged from 123- 276. R113's 9:30 p.m. blood sugars ranged from 102- 221. R113's blood sugars did not indicate notification to the physician.<br><br>During interview on 12/7/17, at 11:15 a.m. director of nursing (DON) stated her expectation was that staff prime the insulin pen each time it was used because the needle is exchanged after each injection. If the insulin pen was not primed before administrating the ordered dose the resident could be given less or more of the required dose and could include air within the injection.<br><br>The facility policy insulin Administration dated 2/17, did not include administration of insulin from an insulin pen.<br><br>Humulin R U- 500 package insert dated 12/29/15, directed to prime the pen before each injection with 5 units. "If you do not prime before each injection, you may get too much or too little insulin."<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could | 21525 | | |

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| 21525 | Continued From page 8<br>develop, review, and/or revise policies and procedures to ensure compliance. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) Days | 21525 | | |
| 21830 | MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 10. Participation in planning treatment; notification of family members.<br><br>(a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.<br>(b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance | 21830 | | 12/7/17 |

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directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the

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| 21830 | Continued From page 10<br>possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to help develop a plan to allow safe smoking as desired for 1 of 1 residents (R110) who wanted to smoke while at the facility and was told staff could not assist her.<br><br>Findings include:<br><br>R110's BIMS (Brief Interview Mental Status) 3.0/Delirium - V2 (assessment used to determine cognition) dated 12/1/17, identified R110 had intact cognition with no mental status changes from her baseline.<br><br>When interviewed on 12/5/17, at 10:10 a.m. R110 stated she would "be happier than punch," if she | 21830 | Corrected | |

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| 21830 | Continued From page 11 | 21830 | | |

could smoke while at the facility for rehabilitation. R110 compared her smoking to other people using anxiety pills and stated her smoking had the same "calming" affect for her adding she would rather smoke than start taking medication like others sometimes have to. R110 stated was physically able to smoke without anyone helping her and I "do everything on my own," but had been told she needed family with her as "that's a rule here I guess," and added "which I think is stupid."

During interview on 12/6/17, at 2:15 p.m. nursing assistant (NA)-A stated R110 was a stand by assist (SBA) with ambulation and spends most of her day inside her room. R110 did, at times, self transfer and walk without staff assistance. Further, NA-A stated R110 had sustained a fall outside while bending over to pick up cigarette butts from the ground, however, added staff were unable to "physically take them [residents]" outside to smoke as it was the facility policy and a non-smoking campus.

When interviewed on 12/6/17, at 2:31 p.m. R110's family member (FM)-D stated smoking was the "most important thing" to R110 and him having to take her outside to smoke "can be very difficult." FM-D stated the facility provided R110 with a nicotine patch, however, nothing else had been discussed or attempted to allow R110 to smoke as she desired, despite R110 repeatedly expressing desires to continue to smoke while at the facility. FM-D asked one of the nurses about allowing R110 to smoke while at the facility, however, they were told R110 would have to sign out and back in and "[R110] would have to do it on her own."

When interviewed on 12/6/17, at 4:34 p.m.

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registered nurse (RN)-A stated residents' who wished to smoke had to do so on their own and without staff assistance as "that's policy here." R110 sustained a fall since she admitted in which she had been outside smoking and fell out of her wheelchair. Since falling, R110 "has asked again" about going out to smoke and other staff have reported to RN-A about her continued desire to smoke, at times, even asking others for cigarettes and offering to pay them for some. RN-A was unaware of any attempts or interventions in place to help R110 smoke while residing at the facility, and added an evaluation to her abilities and desires would be beneficial.

R110's medical record was reviewed and lacked any evidence the facility had worked with R110 to help develop a plan which would allow her to smoke outside as she desired and had requested.

On 12/6/17, at 5:16 p.m. registered nurse care coordinator (RNCC)-B and the director of nursing (DON) were interviewed. DON stated if a resident wished to smoke while residing at the facility, the staff "would create a plan with family and friends," to help them do so. RN-B and DON stated they were unaware of R110's desire to continue smoking, and staff should have reported it so a plan to could be developed to allow her to smoke for her "patient centered care," and "quality of life."

A facility policy on choices was requested, however, none was provided.

SUGGESTED METHOD OF CORRECTION:
The DON or designee could develop policies and procedures regarding resident choices, educate staff, and conduct audits to ensure resident likes

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| 21830 | Continued From page 13<br>and routines are followed by staff.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21830 | | |

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| ST BENEDICTS SENIOR COMMUNITY | 990 19TH STREET SOUTH SARTELL, MN 56377 |

| (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 |
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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health (MDH) 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 | | |

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| 2 000 | Continued From page 1<br><br>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.<br><br>On 12/05/17 to 12/07/17, 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.<br><br>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. | 2 000 | | |

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| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to promote safety with smoking for 1 of 1 residents (R110) who was smoking outside the facility.<br><br>Findings include:<br><br>R110's BIMS (Brief Interview Mental Status) 3.0/Delirium - V2 (assessment used to determine cognition) dated 12/1/17, identified R110 had intact cognition with no mental status changes from her baseline.<br><br>On 12/5/17, at 10:12 a.m. R110 was interviewed in her room. R110 stated she recently had sustained a fall while outside smoking as she bent over in her wheelchair to pick up used cigarette butts from the ground. R110 continued to want to smoke while at the facility, however | 2 830 | corrected | 12/7/17 |

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| 2 830 | Continued From page 3 | 2 830 | | |

stated she needed family with her as "that's a rule here I guess." R110 showed the surveyor a single cigarette on her bedside table and stated the lighter was "somewhere" in her room adding she would "be happier than punch" if she could go outside and smoke. Further, R110 stated she completed all aspects of smoking (i.e. lighting, ashing, disposing) on her own and needed to physical help from staff or others.

R110's progress note dated 11/27/17, identified R110 sustained a fall on 11/24/17, when she "was noted to go outside independently to smoke without assistive device." As a result, R110 was started on nicotine replacement therapy. A subsequent progress note dated 11/29/17, identified R110 was using nicotine replacement therapy and had not smoked since her fall. The note added, "If [R110] desires to begin smoking tobacco again, a formal smoking assessment will be completed."

R110's care plan dated 11/27/17, identified R110 had an alteration in respiratory status related to pneumonia and "smoker status," and listed interventions for staff to provide including administering oxygen, providing medications and, "Nicotine as ordered." The care plan lacked any further information pertaining to R110's smoking.

When interviewed on 12/6/17, at 2:15 p.m. nursing assistant (NA)-A stated R110 does self transfer and walk on her own, however, was not supposed to for her safety. R110 had sustained a fall while outside smoking recently and obtained a "couple abrasions" as a result. NA-A stated she had never personally observed R110 to go out and smoke on her shift, however, heard from other staff R110 had been attempting to go outside "late at night" to smoke still. NA-A stated

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| 2 830 | Continued From page 4<br>residents' who wished to smoke had to go outside on their own according to the policy.<br><br>On 12/6/17, at 2:31 p.m. R110 was wheeled into the building from outside by family member (FM)-D. R110 was dressed in her winter coat and did not have any oxygen on. R110 she was outside having a cigarette. FM-D stated smoking was the "most important thing" for R110 and he was coming to help her smoke outside "every two or three days," since staff at the facility were unable to help her.<br><br>During interview on 12/6/17, at 4:34 p.m. registered nurse (RN)-A stated she had been working the night R110 fell while outside smoking. R110 had gone outside without staff consent or knowledge, and fell while trying to pick up a cigarette butt off the ground sustaining some abrasions and a small cut from the fall. RN-A was unaware if R110 had been outside to smoke, again, since falling on 11/24/17, nor if family was taking her outside to smoke. RN-A stated R110 had "asked again" since falling about going outside to smoke including even asking staff to provide cigarettes to her. RN-A stated she had seen cigarettes in R110's room, most recently "this past Sunday [12/3/17]," however, had not been assessed for her smoking, either supervised or unsupervised, to her knowledge. RN-A stated assessing R110's smoking abilities would be beneficial "just for her [R110] to be safe out there."<br><br>R110's medical record was reviewed and lacked any evidence R110 had been comprehensively assessed for safety with smoking despite still going outside to smoke with family; having sustained a fall while smoking unsupervised; and having cigarettes/lighter(s) on her person. | 2 830 | | |

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| 2 830 | Continued From page 5<br><br>On 12/6/17, at 5:16 p.m. registered nurse care coordinator (RNCC)-B and the director of nursing (DON) were interviewed. R110 was placed on a nicotine patch after falling while outside smoking unsupervised, however, had not been assessed as they thought the nicotine patch was working and going well for R110. Further, DON and RNCC-B were unaware floor staff had found R110 with cigarettes in her room before, and they would "create a safe plan" so R110 could smoke safely going forward.<br><br>A facility Smoking Assessment - Long Term Care policy dated 11/17, identified residents who wished to smoke "need to smoke safely," and listed all residents who choose to smoke "are evaluated and assessed for smoking safety."<br><br>SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee, could provide education to nursing staff about the importance of ensuring assessment is conducted and plans of care followed to ensure residents receive care and supervision in a safe manner related to smoking. The DON or designee, could randomly audit to be sure the proper nursing supervision is provided the residents.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |
| 21525 | MN Rule 4658.1305 A.B.C Pharmacist Service Consultation<br><br>A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who: | 21525 | | 12/7/17 |

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| 21525 | Continued From page 6<br>A. provides consultation on all aspects of the provision of pharmacy services in the nursing home;<br>B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br>C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to ensure an insulin pens was primed prior to dosing and administration of insulin for 1 of 1 residents (R113) who utilized an insulin pen in the facility.<br><br>Findings include:<br><br>R113's BIMS (Brief Interview Mental Status) 3.0/Delirium - V 2 (assessment used to determine cognition) dated 12/1/17, identified R113 had intact cognition with no mental status changes from her baseline. R113's undated Admission Record identified a diagnosis of type 2 diabetes mellitus.<br><br>R113's physician orders signed 11/25/17, directed staff to administer subcutaneous via pen, Humlin R U-500 (insulin used to control blood sugar) 75 units at breakfast, 40 units at lunch and 75 units at dinner.<br><br>During observation on 12/6/17, at 5:15 p.m. registered nurse (RN)-C used an alcohol wipe to cleanse the end of the insulin pen, then attached the needle. RN-C then dialed the insulin pen to 75 units and administered the dose in R113's left | 21525 | Corrected | |

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| 21525 | Continued From page 7 | 21525 | | |

abdomen. RN-C did not prime the insulin pen with 5 units prior to dialing and administrating the 75 units of insulin.

During interview on 12/6/17, at 5:55 p.m. RN-C stated she did not prime the insulin pen prior to administrating the ordered dose as the pen had been continuously used and was not a new pen.

R113's December 2017 medication administration record identified R113's blood sugar levels were checked four times daily. R113's blood sugars at 7:30 a.m. ranged from 92 to 140. R113's 11:30 a.m. blood sugars ranged from 204- 325. R113' 5:00 p.m. blood sugars ranged from 123- 276. R113's 9:30 p.m. blood sugars ranged from 102- 221. R113's blood sugars did not indicate notification to the physician.

During interview on 12/7/17, at 11:15 a.m. director of nursing (DON) stated her expectation was that staff prime the insulin pen each time it was used because the needle is exchanged after each injection. If the insulin pen was not primed before administrating the ordered dose the resident could be given less or more of the required dose and could include air within the injection.

The facility policy insulin Administration dated 2/17, did not include administration of insulin from an insulin pen.

Humulin R U- 500 package insert dated 12/29/15, directed to prime the pen before each injection with 5 units. "If you do not prime before each injection, you may get too much or too little insulin."

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could

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| 21525 | Continued From page 8<br>develop, review, and/or revise policies and procedures to ensure compliance. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) Days | 21525 | | |
| 21830 | MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 10. Participation in planning treatment; notification of family members.<br><br>(a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.<br>(b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance | 21830 | | 12/7/17 |

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directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the

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| 21830 | Continued From page 10<br>possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to help develop a plan to allow safe smoking as desired for 1 of 1 residents (R110) who wanted to smoke while at the facility and was told staff could not assist her.<br><br>Findings include:<br><br>R110's BIMS (Brief Interview Mental Status) 3.0/Delirium - V2 (assessment used to determine cognition) dated 12/1/17, identified R110 had intact cognition with no mental status changes from her baseline.<br><br>When interviewed on 12/5/17, at 10:10 a.m. R110 stated she would "be happier than punch," if she | 21830 | Corrected | |

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could smoke while at the facility for rehabilitation. R110 compared her smoking to other people using anxiety pills and stated her smoking had the same "calming" affect for her adding she would rather smoke than start taking medication like others sometimes have to. R110 stated was physically able to smoke without anyone helping her and I "do everything on my own," but had been told she needed family with her as "that's a rule here I guess," and added "which I think is stupid."

During interview on 12/6/17, at 2:15 p.m. nursing assistant (NA)-A stated R110 was a stand by assist (SBA) with ambulation and spends most of her day inside her room. R110 did, at times, self transfer and walk without staff assistance. Further, NA-A stated R110 had sustained a fall outside while bending over to pick up cigarette butts from the ground, however, added staff were unable to "physically take them [residents]" outside to smoke as it was the facility policy and a non-smoking campus.

When interviewed on 12/6/17, at 2:31 p.m. R110's family member (FM)-D stated smoking was the "most important thing" to R110 and him having to take her outside to smoke "can be very difficult." FM-D stated the facility provided R110 with a nicotine patch, however, nothing else had been discussed or attempted to allow R110 to smoke as she desired, despite R110 repeatedly expressing desires to continue to smoke while at the facility. FM-D asked one of the nurses about allowing R110 to smoke while at the facility, however, they were told R110 would have to sign out and back in and "[R110] would have to do it on her own."

When interviewed on 12/6/17, at 4:34 p.m.

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registered nurse (RN)-A stated residents' who wished to smoke had to do so on their own and without staff assistance as "that's policy here." R110 sustained a fall since she admitted in which she had been outside smoking and fell out of her wheelchair. Since falling, R110 "has asked again" about going out to smoke and other staff have reported to RN-A about her continued desire to smoke, at times, even asking others for cigarettes and offering to pay them for some. RN-A was unaware of any attempts or interventions in place to help R110 smoke while residing at the facility, and added an evaluation to her abilities and desires would be beneficial.

R110's medical record was reviewed and lacked any evidence the facility had worked with R110 to help develop a plan which would allow her to smoke outside as she desired and had requested.

On 12/6/17, at 5:16 p.m. registered nurse care coordinator (RNCC)-B and the director of nursing (DON) were interviewed. DON stated if a resident wished to smoke while residing at the facility, the staff "would create a plan with family and friends," to help them do so. RN-B and DON stated they were unaware of R110's desire to continue smoking, and staff should have reported it so a plan to could be developed to allow her to smoke for her "patient centered care," and "quality of life."

A facility policy on choices was requested, however, none was provided.

SUGGESTED METHOD OF CORRECTION:
The DON or designee could develop policies and procedures regarding resident choices, educate staff, and conduct audits to ensure resident likes

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 31401 | A. BUILDING: _____ B. WING _____ | 12/07/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST BENEDICTS SENIOR COMMUNITY | 990 19TH STREET SOUTH SARTELL, MN 56377 |

| (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 |
|---|---|---|---|---|
| 21830 | Continued From page 13<br>and routines are followed by staff.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21830 | | |