CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY					ID: BR8Y	
1. MEDICARE/MEDICAID PROVIDER 1 (L1) 245350 2.STATE VENDOR OR MEDICAID NO. (L2) 885740700		3. NAME AND AD (L3) ST BENEDIC (L4) 1810 MINNE (L5) SAINT CLO	DRESS OF FACIL CTS SENIOR C	LITY COMMUNI	тү	Facility ID: 00774 4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OWN (L9) 6. DATE OF SURVEY 02/28/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION From (a): To (b):		7. PROVIDER/SUI 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF 10.THE FACILITY X A. In Complian Program R	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	09 ESRD 10 NF 11 ICF/IID 12 RHC	03 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE And/Or Approved Waivers Of The 2. Technical Personnel	8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 06/30
12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDOW!	174 (L18) 174 (L17)	Complianc1. A B. Not in Con	the Based On: Acceptable POC Inpliance with Progrand/or Applied Wai			7. Medical Director
18 SNF 18/19 SNF 2 172 (L37) (L38) 16. STATE SURVEY AGENCY REMARK	19 SNF (L39)	ICF (L42) E SHOW LTC CANCE	IID (L43) ELLATION DATE)):	1861 (e) (1) or 1861 (j) (1):	(L15)
17. SURVEYOR SIGNATURE Kathleen Lucas, Uni	t Supervis	Date : 0	03/25/2020	(L19)	18. STATE SURVEY AGENCY A	
PA	RT II - TO BE	COMPLETED	BY HCFA RE	EGIONAL	OFFICE OR SINGLE ST	ATE AGENCY
19. DETERMINATION OF ELIGIBILITY _X			IPLIANCE WITH (GHTS ACT:	CIVIL	21. 1. Statement of Finan 2. Ownership/Control 3. Both of the Above	I Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 09/15/1986 (L24) (L41)			4. LTC AGREEM ENDING DAT		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	05-Fail to Meet Health/Safety
25. LTC EXTENSION DATE: (L27)	ALTERNATIV A. Suspension B. Rescind Sus	of Admissions:	(L44) (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMARKS	
	(L28)	03001		(L31)		

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

03/11/2020

(L32)

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 25, 2020

Administrator St Benedicts Senior Community 1810 Minnesota Boulevard Southeast Saint Cloud, MN 56304

RE: CCN: 245350

Cycle Start Date: January 16, 2020

Dear Administrator:

On February 28, 2020, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Towers Stapeon

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 25, 2020

CMS Certification Number (CCN): 245350

Administrator St Benedicts Senior Community 1810 Minnesota Boulevard Southeast Saint Cloud, MN 56304

Dear Administrator:

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 March 23, 2020 the above facility is certified for:

2 Skilled Nursing Facility Beds

172 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 174 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Towers Stapson

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

PRINTED: 03/09/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED				
		245350	B. WING				R 28/2020	
	PROVIDER OR SUPPLIER	MUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
{E 000}	Initial Comments		{E 00	00}				
{F 000}	Emergency Prepare	ey exited on 1/16/20.	{F 00	00}				
	the facility was four deficiencies issued exited on 1/16/20. T compliance with red	vas completed on 2/28/20, and and to have corrected all as a result of the survey The facility is back in quirements of 42 CFR Part d Requirements for Long Term						
	signature is not req page of the CMS-2 correction is require	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of of the electronic documents						

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.		 	₹
		00774	B. WING			8/2020
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST BENE	EDICTS SENIOR COM	MIINITY	NESOTA BO .OUD, MN 5	OULEVARD SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 000} Initial Comments		{2 000}				
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall	Minnesota Statute, section ction order has been issued by. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all e rule provided at the tagule number indicated below. In several items, failure to the items will be considered. Lack of compliance upon any item of multi-part rule will ement of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	INITIAL COMMEN	rs:				
{21010}	MN Rule 4658.0610 Requirements-Eatin	0 Subp. 6 Dietary Staff ng.	{21010}			
		III employees must consume designated for employee				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00774	B. WING		02/2	R 18/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST BENE	EDICTS SENIOR COM	MUNITY	NESOTA BO OUD, MN 56	ULEVARD SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
{21010}	dining. An employed designated if consuculd cause contant	ee dining area must not be ming food in that location nination of other food,	{21010}			
	apply to cooks or ot	sils. This subpart does not her persons designated by ne food for flavor and				
	This MN Requirements	ent is not met as evidenced				
{21530}	MN Rule 4658.1310	A.B.C Drug Regimen Review	{21530}			
	reviewed at least m currently licensed be This review must be Appendix N of the Surveyor Procedure Requirements in Lot the Department of Health Care Finance This standard is incavailable through the system. It is not sue B. The pharma irregularities to the and the attending period must be acted upor physician visit, or see pharmacist. For pure upon means the acreport and the signification of nursing services C. If the attend with the pharmacist	en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ing-Term Care, published by Health and Human Services, ing Administration, April 1992. corporated by reference. It is e Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports by the time of the next coner, if indicated by the rposes of this part, "acted coceptance or rejection of the ing or initialing by the director and the attending physician. Ing physician does not concur's recommendation, or does te justification, and the				

6899

Minnesota Department of Health STATE FORM

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMPI	
		00774	B. WING		R 02/2	R 8/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST BENE	DICTS SENIOR COM	MUNITY		ULEVARD SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	OUD, MN 50 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
{21530}	being adversely affirefer the matter to the firefer the matter to the firefer the medical direct physician. If the medical the attending physician for the exphysician does not must be referred for assessment and as by part 4658.0070, the medical direct must refer the matter assessment and as a session of the medical direct formust refer the matter assessment and as a session of the medical direct formust refer the matter assessment and as a session of the medical direct formust refer the matter assessment and as a session of the medical direct formust refer the matter assessment and as a session of the medical direct formust refer the matter as a session of	ge 2 s the resident's quality of life is ected, the pharmacist must he medical director for review for is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter or review to the quality esurance committee required. If the attending physician is or, the consulting pharmacist er directly to the quality esurance committee.	{21530}			
{21805}	Residents of HC Fa Subd. 5. Courteouresidents have the courtesy and respe employees of or pe health care facility.	ac.Bill of Rights us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a ent is not met as evidenced	{21805}			
{21830}	Residents of HC Fa	.651 Subd. 10 Patients & ac.Bill of Rights pation in planning treatment;	{21830}			
	notification of family					

Minnesota Department of Health

STATE FORM BR8Y12 If continuation sheet 3 of 6

	na Department of Tie					0.15.75.7
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
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					F	₹
		00774	B. WING		02/2	8/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
TW WILL OF	THO VIDER OR GOLF EIER			ULEVARD SOUTHEAST		
ST BENE	EDICTS SENIOR COM	MUNITY	OUD, MN 50			
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PRÉFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				,		
{21830}	Continued From page 3		{21830}			
	(a) Residents shal	I have the right to participate				
		neir health care. This right				
		unity to discuss treatment and				
		lividual caregivers, the				
		est and participate in formal				
		and the right to include a				
		ther chosen representative or				
		hat the resident cannot be				
		ember or other representative				
		lent may be included in such				
	conferences.	lent may be included in Such				
		vho enters a facility is				
		natose or is unable to				
		acility shall make reasonable				
		under paragraph (c) to notify				
		ber or a person designated in				
		ent as the person to contact in				
		the resident has been				
		lity. The facility shall allow the				
		articipate in treatment				
		e facility knows or has reason				
	. 0	ent has an effective advance				
		trary or knows the resident has				
		that they do not want a family				
		treatment planning. After				
		ember but prior to allowing a				
		articipate in treatment				
		/ must make reasonable				
		vith reasonable medical				
		ne if the resident has				
		ce directive relative to the				
	esident's health car	e decisions. For purposes of				
		asonable efforts" include:				
		e personal effects of the				
	resident;	•				
		e medical records of the				
		session of the facility;				
		ny emergency contact or				

6899

Minnesota Department of Health STATE FORM

PRINTED: 03/09/2020 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING:		_	_
	00774	B. WING		02/2	₹ 28/2020
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST BENEDICTS SENIOR COMMU	UNITY	NESOTA BO OUD, MN 56	ULEVARD SOUTHEAST 3304		
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whether the resident had irective and whether physician to whom the care; and (4) inquiring of the president normally goes whether the resident had irective. If a facility not designated emergency member to participate accordance with this pliable to resident for determined the notification of the free mergency contact or family member was in patient's privacy rights (c) In making reason family members or a designate examining the personand the medical recompossession of the facility shall attemped members or a designate examining the personand the medical recompossession of the facility notify a family member or designated the facility has been under the facility has been under the facility has been under the facility is social service and the mergency sidentifying and notifying designated emergency service agency or locathat assists a facility is subdivision is not liable.	cted under this section has executed an advance the resident has a e resident normally goes for physician to whom the es for care, if known, has executed an advance notifies a family member or ey contact or allows a family e in treatment planning in paragraph, the facility is not lamages on the grounds that family member or r the participation of the mproper or violated the s. conable efforts to notify a signated emergency contact, put to identify family ated emergency contact by hal effects of the resident rds of the resident in the ility. If the facility is unable her or designated ithin 24 hours after the r shall notify the county or local law enforcement ent has been admitted and unable to notify a family and emergency contact. The agency and local law shall assist the facility in ng a family member or ey contact. A county social al law enforcement agency in implementing this	{21830}			

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			A. BOILDING	•		٦
		00774	B. WING			8/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
ST BENE	EDICTS SENIOR COM	MILINITY	NESOTA BO LOUD, MN 5	OULEVARD SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
{21830}	Continued From pa	ge 5	{21830}			
	the family member	or emergency contact or the family member was improper				
	This MN Requiremby:	ent is not met as evidenced				

Minnesota Department of Health

STATE FORM BR8Y12 If continuation sheet 6 of 6

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL TE SURVEY AGENCY		BR8Y ility ID: 00774
1. MEDICARE/MEDICAID PROVIDER (L1) 245350 2.STATE VENDOR OR MEDICAID NO. (L2) 885740700 5. EFFECTIVE DATE CHANGE OF OV (L9)		3. NAME AND ADDRESS OF FACILITY (L3) ST BENEDICTS SENIOR COMMUNIT (L4) 1810 MINNESOTA BOULEVARD SOU (L5) SAINT CLOUD, MN 7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD				4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation 7. On-Site Visit 8. Full Survey After Comp	2 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other
6. DATE OF SURVEY 01/16 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/ 2020 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING D 06/30	ATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	174 (L18) 174 (L17)	Compliance 1. A X B. Not in Cor	nce With Requirements ce Based On: Acceptable POC mpliance with Pro	gram	And/Or Approved Waivers Of T 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code		r
14. LTC CERTIFIED BED BREAKDOV 18 SNF 18/19 SNF 2 172 (L37) (L38) 16. STATE SURVEY AGENCY REMAI	19 SNF (L39)	ICF (L42)	IID (L43)		* Code: B 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L12) (L15)	
17. SURVEYOR SIGNATURE Kathleen Lucas, Unit		Date :	03/09/2020		18. STATE SURVEY AGENCY Douglas Larson, En	APPROVAL Iforcement Specialis	Date: t 03/10/2020
P	ART II - TO BF	COMPLETED	BY HCFA R	(L19) EGIONAI	OFFICE OR SINGLE ST	TATE AGENCY	(L20
DETERMINATION OF ELIGIBILIT	Y articipate	20. COM	IPLIANCE WITH GHTS ACT:		21. 1. Statement of Fina	ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA	A-1513)
22. ORIGINAL DATE OF PARTICIPATION 09/15/1986 (L24) 25. LTC EXTENSION DATE: (L27)	23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIV A. Suspension B. Rescind Sus	DATE /E SANCTIONS of Admissions:	4. LTC AGREEI ENDING DA (L25)		26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursen 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	00 INVOLUNTAL 05-Fail to Meet 06-Fail to Meet	RY I Health/Safety t Agreement
28. TERMINATION DATE:	29.	INTERMEDIARY/O	(L45) CARRIER NO.		30. REMARKS		

(L31)

(L33)

DETERMINATION APPROVAL

03001

32. DETERMINATION OF APPROVAL DATE

(L28)

(L32)

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 30, 2020

Administrator St Benedicts Senior Community 1810 Minnesota Boulevard Southeast Saint Cloud, MN 56304

RE: CCN: 245350

Cycle Start Date: January 16, 2020

Dear Administrator:

On January 16, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

St Benedicts Senior Community January 30, 2020 Page 2

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

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

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

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B 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: kathleen.lucas@state.mn.us

Phone: (320) 223-7343 Fax: (320) 223-7348

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

St Benedicts Senior Community January 30, 2020 Page 3

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 16, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 16, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

St Benedicts Senior Community January 30, 2020 Page 4

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.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit Health Regulation Division

July Stapeon

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

PRINTED: 03/09/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(С
		245350	B. WING			01/	16/2020
NAME OF F	PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
ST BENE	EDICTS SENIOR COM	IMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		ΕO	00			
F 000	Emergency Prepare conducted 1/13/20 recertification surve	liance with CMS Appendix Z edness Requirements, was to 1/16/20, during a ey. The facility is in compliance Z Emergency Preparedness	F 0	00			
	On 1/13/20 to 1/16 conducted at your finvestigations were was found not to be requirements of 42	s/20 a standard survey was					
	The following comp substantiated: H5350091C. No de H5350092C. No de H5350094C. No de The following comp unsubstantiated: H5350090C	ficiencies issued. ficiencies issued. ficiencies issued.					
	as your allegation of Department's acce enrolled in ePOC, y at the bottom of the form. Your electron be used as verification	·					
LABORATOR	on-site revisit of you	acceptable electronic POC, an ur facility may be conducted to DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

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.

Electronically Signed

02/07/2020

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245350	B. WING	·			C 16/2020
	PROVIDER OR SUPPLIER	IMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304			10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	regulations has bee	antial compliance with the en attained in accordance with	F(000			
F 550 SS=D	Resident Rights/Ex CFR(s): 483.10(a)(F 5	550			2/24/20
	self-determination, access to persons	nt Rights. right to a dignified existence, and communication with and and services inside and including those specified in					
	with respect and di resident in a manne promotes maintena her quality of life, re	cility must treat each resident gnity and care for each er and in an environment that ance or enhancement of his or ecognizing each resident's acility must protect and of the resident.					
	access to quality caseverity of condition must establish and practices regarding provision of services	facility must provide equal are regardless of diagnosis, n, or payment source. A facility maintain identical policies and transfer, discharge, and the es under the State plan for all as of payment source.					
		ne right to exercise his or her to find the facility and as a citizen					
	resident can exerci	facility must ensure that the se his or her rights without ion, discrimination, or reprisal					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTII A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245350	B. WING		01/16/	2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAS SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE CO	(X5) DMPLETION DATE
F 550	Continued From pa		F 550			
	free of interference reprisal from the farights and to be surexercise of his or his subpart. This REQUIREME by: Based on observative review, the facility resident was proview who waited for 33 answered. In additional a catheter bag confrom public view for residing on the unitary findings include: R112's admission dated 12/29/19, idea cognitive impairment assistance with action of the cognitive impairment as a cognitive impai	Minimum Data Set (MDS) entified R112 had moderate ent and required extensive tivities of daily living (ADLs) rea Assessment (CAA) dated d R112 was unsteady when k, turn, move on and off toilet, red, needed staff assist to story of falling, with a fall in pted to self-transfer. evised 12/15/19, identified are deficit related to weakness, ventions included assistance of		R112 scare plan was updated of 1/14/2020 indicating for staff to staresident while on the toilet. R73 scatheter bag was covered with a pbag on 1/16/2020. Staff will receive education on the importance of maintaining resident dignity, including responding to respect within a timely manner. Staff also receive education on covering catheter drainage bags. A standard has been created within our electromedical record which can be readifus assigned as a reminder for staff to urinary drainage bags with a private for those residents whom use a uricatheter. Random observational audits will be completed to assure that residents use a urinary catheter drainage bathat bag within a privacy bag. These audits will be conducted weekly for month, then monthly until the next Quarterly Assurance committee.	ay with urinary rivacy t□s sident ff will g urinary d task onic ly cover cy bag, inary oe s whom g, have se r one	
	assistance of one plan also indicated	er with wheeled walker and staff with toileting needs. Care I R112 had a potential for injury f falls. did not consistently use		The Director of Nursing and/or des will report the findings of the audits quarterly Quality Assurance comm	at the	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	COV	TE SURVEY MPLETED C
		245350	B. WING_			/16/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1810 MINNESOTA BOULEVARD SOU SAINT CLOUD, MN 56304	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 550	call light, had poor self-transferred. Cincluded call light kencourage R112 to pendant call light, r self-transfers was fractures and injuri. During interview or member (FM)-A statoilet for an extend utilized both the bapendant worn on a stated the family had facility on 1/12/20, they (the facility we R112 had the call I had transferred sel wheelchair, there we stated R112 requir concerned there concerned ther	safety awareness, and are planed interventions are planed interventions. Outilize call light, R112 had risks and consequences of discussed which included falls, are up to and including death. In 01/13/20, at 1:08 p.m. family ated R112 had been left on the ed period of time, R112 had throom pull cord in addition to chain around the neck. FM-A and received phone call from caller had apologized, stated are in the wrong) then stated ight on for over 30 minutes, are in the word of the ware no injuries. FM-A further and assistance to transfer, was build have been a fall with a R112 was seated next to and repeatedly stated "they left to come back, I had the lights are the care plan had the lights are the care plan had not eat staff to stay in the abathroom call light and and light had been on for 33 uired assistance of one staff	F 58	determination will be made interventions are warranted determine the frequency for audits.	as well as to	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245350	B. WING		C 01/16/2020	
	PROVIDER OR SUPPLIER	MUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEA SAINT CLOUD, MN 56304	•	
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F 550	stated R112 was le according to call lig light and pendant or minutes, facility wa had independently RN-B further stated service, call lights staff within ten minutes at the service of the pendage of t	on 1/16/20, at 9:18 a.m. RN-B ft on the toilet alone, ht report the bathroom call all light had been on for 33 s not sure at what point R112 transferred to the wheelchair. I this was poor customer should have been answered by utes. evice Activity Report with ted 1/16/20, identified R112 ant call light on 1/12/20, at lant being cleared by staff at it had been on for 34 minutes stated that was when R112 it to be placed on the toilet. On im. R112 utilized pendant call a.m. R112 utilized bathroom been on for 29 minutes 51 call light was cleared by which had been on for 33. RN-B stated this was not	F 550			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245350	B. WING		01	/16/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 1810 MINNESOTA BOULEVARD SOUTH SAINT CLOUD, MN 56304	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 550	R73's Urinary/Indv 12/7/19, identified in place. During observation urinary catheter ba hanging uncovered (specialty reclining room. At 5:48 p.m was hanging below uncovered. When observed of catheter bag contauncovered below In At 1:48 p.m. R73 ocatheter bag contauncovered below In R73 continued to Incontaining urine has chair visible from Interviewed of was in room with uncovered, visible when interviewed nursing assistant (grab a dignity bag be in place to prote the protection of the protection of the protection of the place to protect and the protection of the place to protect and the	velling Catheter CAA dated R73 had an indwelling catheter an on 1/13/20, at 12:25 p.m. ag with urine inside was debelow R73's Broda chair wheelchair) at table in dining a catheter bag containing urine was broda chair in dining room an 1/14/20, at 8:34 a.m. Urinary aining urine was hanging Broda chair in the dining room. Was in room with urinary aining urine hanging below from hallway. At 3:15 p.m. have urinary catheter bag anging uncovered below Broda hallway.	F 550			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	СОМ	E SURVEY IPLETED
		245350	B. WING			C 16/2020
	PROVIDER OR SUPPLIER	MUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAS SAINT CLOUD, MN 56304		10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 578	hallway. When interviewed of stated urinary cather for resident dignity. During phone interviewed of the urine in the cath when interviewed of stated privacy bags residents with cather dignity. A facility Dignity Po Bed revised 6/2019 assist the resident the self-worth and dignity Request/Refuse/Ds CFR(s): 483.10(c)(6) The rediscontinue treatments.	on 1/15/20, at 2:08 p.m. RN-A eter bags were to have covers view on 1/16/20, at 9:14 a.m. as a very dignified person ogressed, R73 would be upset to know other people could see neter bag. on 1/16/20, at 9:29 a.m. RN-B were to be in place for all eter drainage bags for their licy - Long Term Care/Swing in identified all staff were to to maintain and enhance ity. scentnue Trmnt;FormIte Adv Dir 6)(8)(g)(12)(i)-(v) right to request, refuse, and/or ent, to participate in or refuse perimental research, and to	F 578			2/24/20
	§483.10(c)(8) Nothi construed as the rig the provision of me	ing in this paragraph should be ght of the resident to receive dical treatment or medical nedically unnecessary or				
		facility must comply with the fied in 42 CFR part 489, Directives).				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER EDICTS SENIOR COM			STREET ADDRESS, CITY, STATE, ZIP 1810 MINNESOTA BOULEVARD S SAINT CLOUD, MN 56304	CODE	
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F 578	(i) These requirem inform and provide residents concerning medical or surgical resident's option, for (ii) This includes a facility's policies to and applicable Sta (iii) Facilities are pentities to furnish the legally responsible requirements of this (iv) If an adult indivitime of admission a information or article has executed an amay give advance individual's resident with State Law. (v) The facility is not provide this inform or she is able to refollow-up proceduthe information to the appropriate time. This REQUIREME by: Based on interview facility failed to ensure wishes identification record to ensure sidentified diagnose identified diagnose identified diagnose individuals.	ents include provisions to written information to all adult ng the right to accept or refuse I treatment and, at the ormulate an advance directive. written description of the implement advance directives te law. ermitted to contract with other his information but are still for ensuring that the	F 5	Staff met with R228 on 1/verify the resident's wishes the noted discrepancy. The electronic medical record awere updated to corresport A full facility audit was con 1/14/2020. R228 was the cobe impacted by the electronic record and paper chart not appropriately. Staff received an appropriately capturing	s in response to e resident's and paper chart nd appropriately. ducted on only resident to inic medical t corresponding ed re-education	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION		SURVEY PLETED
		245350	B. WING			01/1	C 16/2020
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	<u> U1/1</u>	10/2020
ST BENI	EDICTS SENIOR COM	IMUNITY		18	810 MINNESOTA BOULEVARD SOUTHEAS AINT CLOUD, MN 56304	т	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE
F 578	sepsis (blood infect also identified R226 Code" (person will to get their heart st R228's admission I dated 12/30/19, ide intact and required activities of daily liv Review of R228's eincluded "Full Code initial page, and inc 12/24/19, identifyin Review of R228's pan Advance Directi signed by R228 on R228's physician or R228's physician or R228's preference Resuscitate) In the witnessed respirator resuscitation shall sudden respiratory intubation (tubes plungs) should not be emergency manage. During a review of 12/24/19, at 8:59 prigned DNR, waiting During an interview registered nurse (Found unresponsive official advance directions).	tion). The admission record 8's advance directive as "Full allow all interventions needed arted). Minimum Data Set (MDS), entified R228 was cognitively extensive assistance for ring. Electronic medical record e" listed on the top of R228's cluded a physician order, dated g "Full Code." Daper medical record included the Consent Form, dated and 12/24/19, and signed by n 12/26/19, which indicated was "DNR (Do Not event of witnessed cardiac or ory arrest, no cardiopulmonary be initiated. In the event of failure, endotracheal faced from the mouth into the see done. This does not include ement in case of choking." R228's progress notes, dated .m. included, "Pt. [patient] ag on MD signature." on 1/14/20, at 9:57 a.m. RN)-D stated, if a resident was e, the paper chart included the ective preference of the the appropriate place to	F	578	implementing residents' advance directive/code status wishes. Random chart audits will be compleasure that resident's advance direwishes are consistent within the elemedical record to the wishes indicated the Advance Directive form within the paper chart. These audits will be conducted weekly for one month, the monthly until the next "Quarterly Assurance" committee. The Director of Nursing and/or deswill report the findings of the audits quarterly "Quality Assurance" commandetermination will be made if furtinterventions are warranted as well determine the frequency for ongoin audits.	ective ectronic ated on he hen ignee at the mittee. her as to	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
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	PROVIDER OR SUPPLIER	IMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODI 1810 MINNESOTA BOULEVARD SOUTH SAINT CLOUD, MN 56304	E	1710/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPORT DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 578	During an interview RN-E stated, "We were the paper chart become reviewed with familiary and interview RN-H stated she were cord or to the election however, "I would at the interviewed stated, "Their [resident on PCC [Point Clicare cord utilized by the initial page on R22 RN-F stated, "That at their code status During an interview RN-I stated, "I would because that's whe documentation would would be remarked thought it was in the wasn't sure. R228 to not be resuscitate husband passed as watched as emerger resuscitate him. R2	on 1/14/20, at 9:58 a.m. would always go by what's in cause that is what's been ly and the doctor." on 1/14/20, at 10:00 a.m. rould go to the paper medical actronic medical record, always look at the signed form on 1/14/20, at 10:04 a.m. RN-F dents] code status is right here, k Care] [electronic medical record. The facility]," pointing to the 8's electronic medical record. The where I always check. I look is before I go into their room." on 1/14/20, at 10:05 a.m. Id go look at the paper chart ere the most current		78		
	During a follow up p.m. RN-F stated s approximately seve	interview on 1/14/20, at 12:20 the had worked at the facility en months, and stated, "You nen a code blue [universally				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	COM	E SURVEY IPLETED C
		245350	B. WING _		ı	16/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHE SAINT CLOUD, MN 56304		
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F 578	recognized emergestops breathing or never been involved process is to call of then several peoply have a job. I'm not charge of verifying together to do what when interviewed RN-G stated, "We breathing, alert the in the patient's character of should make that is in the [paper in the event that it's blue procedure. Hat process." During an interviewed include check the code status. It was admitted, the hospital included the devent of someone their code status. It was admitted, the hospital included the did admitting nurse allowed in the resident, using the Form, and the resident information to ensure changes should always mat	ency code when someone has no pulse] happens. I have ad in one, but I know that the ode blue on the walkie, and e respond. All of those people sure, but I think someone is in the code status. We all work the resident has determined." on 1/14/20, at 12:26 p.m. check to see if they are to other staff, check code status art, the signed copy from the er chart and electronic medical ch, but the best place to verify a chart. That always happens, a full resuscitation, start code appens on all shifts, that is the expectation of the process cking the paper chart in the being unresponsive, to verify DON indicated when a resident discharge orders from the ne code status, and the ways verifies that with the Advance Directive Consent dent signed the form and it was ent's paper chart. DON stated, in staff and nursing work jointly get made in the record. They ch."	F 57	78		
	Record, located or (a wheeled contain	ity's undated Code Blue the facility's emergency cart er carrying medicine and in emergency resuscitations),				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDII	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245350	B. WING_			C 16/2020
	PROVIDER OR SUPPLIER	MUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CORRECTION OF THE	D BE	(X5) COMPLETION DATE
F 578	line for a signature. at 1:15 p.m. DON in verify the code state Advance Directive of most current prefer and physician. Review of the facility revised 4/11, include wishes regarding A obtained by Informathe admission procesupervisor will cheep between resident worderDiscussions family members, ar clearly documented Advance Directives packet of the chart	TATUS VERIFIED BY:" with a When interviewed on 1/14/20, ndicated staff are directed to us in the paper record, on the Consent Form, as this was the ence, signed by the resident by's policy, Advance Directives, led, "Resident and/or family dvance Directives are ation and Registration during essThe RN Evening ck orders for agreement vishes and physician's with physician, resident, and nursing staff need to be a goes into the physician order for signing. A duplicate is filed ective" section of the chart."	F 5	78		
F 755 SS=D	4/14, included, "Whrespiratory arrest the immediately verified not include direction used to verify the complex process." CFR(s): 483.45(a)(limits) (limits) (limits	ary Resuscitation, revised nen a resident has a cardiac or ne resident's code status is d," however, the policy does n as to what source should be ode status. rocedures/Pharmacist/Records b)(1)-(3)	F 7	55		2/24/20

		` IDENTIFICATION NUMBED: \ ` ´		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		245350	B. WING		01/16/2020	
	PROVIDER OR SUPPLIER	MUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAS SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION	
F 755	permits, but only use a licensed nurse. §483.45(a) Proced pharmaceutical set that assure the accedispensing, and adbiologicals) to mee §483.45(b) Services must employ or ob pharmacist whospects of the provide facility. §483.45(b)(1) Provide facility. §483.45(b)(2) Estarcceipt and disposis sufficient detail to expect and that an assument as maintained and proceding the provide facility. §483.45(b)(3) Detection order and that an assument as the provide facility and the provide facility. §483.45(b)(3) Detection order and that an assument as the provide facility. Based on observation documentation, the medication orders residents (R48) revised facility and the provide facility.	ures. A facility must provide rvices (including procedures curate acquiring, receiving, lministering of all drugs and it the needs of each resident. Consultation. The facility tain the services of a licensed rides consultation on all rision of pharmacy services in blishes a system of records of tion of all controlled drugs in enable an accurate remines that drug records are in account of all controlled drugs periodically reconciled. NT is not met as evidenced tion, interview, and a facility failed to ensure were clarified for 1 of 5 viewed for unnecessary and two Maalox as needed red, the facility failed to ensure of 6 medication rooms in aborhood was removed and not	F 758	R48's Maalox order was clarified of 1/15/2020, leaving only one available needed order". As noted within the statement of deficiency, the expire tuberculin was immediately dispose 1/15/2020. Nursing staff will receive education need to review provider orders for need for clarifications such as parafor use and/or elimination of potent duplicative orders.	ole "as d vial of ed on on the the ameters	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245350	B. WING				C 16/2020
	PROVIDER OR SUPPLIEF				TREET ADDRESS, CITY, STATE, ZIP CODE 810 MINNESOTA BOULEVARD SOUTHEAS SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	R48's quarterly Mi 11/12/19, indicate term memory issu assist with transfe and eating. R48's Diagnosis F a diagnosis of gas (GERD). R48's Order Summas needed (PRN) prescribed on 7/18 suspension 200-2 mouth every 2 hours as needed orders did not direct's or visa versa. Review of R48's Necords (MAR) si 7/15/19, identified times. R48's July received 20 cc of a.m. R48's Augus received 20 cc of a.m. R48's record received 20 cc docreticed 20 cc do	mimum Data Set (MDS), dated d R48 had short term and long es. R48 required extensive rs, dressing, personal hygiene, Report, printed 1/15/20, included stro-esophageal reflux disease mary Report, identified 2 current orders for Maalox both 5/19. 1) Maalox regular strength 00-20 mg/5 ml. Give 10 cc by urs as needed for indigestion, a regular strength suspension ml. Give 20 cc by mouth every d for indigestion, nausea. The ect when to give 10 cc versus 20	F 7	755	A process was identified to review semedications for expiration/beyond udates. This process will be completed monthly. Random chart audits will be completed throughout the units within facility to ensure that orders are being clarified parameters for use and/or eliminatic potentially duplicative orders. Randobservational audits will be completed check for medications which are expired/beyond use. The Director of Nursing and/or designated will report the findings of the audits quarterly "Quality Assurance" command determine if further intervention warranted as well as to determine the frequency for ongoing audits.	eted of ed for on of om ted to eat the nittee is are	
	licensed practical she would adminis reviewed R48's Ja R48 had indigestic receive 20 cc of M second order for M	nurse (LPN)-D was asked how ster Maalox to R48. LPN-D anuary 2020 MAR and stated if on or nausea, R48 would laalox. When directed to R48's Maalox 10 cc, LPN-D stated "Oh an order for 10 cc as well.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	I \ /	TE SURVEY MPLETED C
		245350	B. WING _		01	/16/2020
	PROVIDER OR SUPPLIER	MUNITY		STREET ADDRESS, CITY, STATE, ZIP CO 1810 MINNESOTA BOULEVARD SOU SAINT CLOUD, MN 56304	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 755	LPN-D then stated then after 2 hours, not better would th LPN-D stated orde when there are diff R48's order did not Maalox ordered. During an interview consulting pharma catch dosage discreviews. CP-A state physician to clarify cc or 20 cc PRN. The facility's policy 10/11, directed phy the staff RN or LPI LPN, or health info accordance with properties and fills the prescrithe night nurse (or order was received all new orders are	she would give the 10 cc first, if indigestion or nausea was en probably administer 20 cc. rs generally have perimeters erent dosages ordered, but thave perimeters for the von 1/15/20, at 12:06 p.m. the cist (CP)-A stated he try's to repancies during is monthly ed R48's Maalox order was ed he would recommend the the Maalox order for either 10 rephysician Orders, dated vsician orders are obtained by and transcribed by the RN, rmation specialist in rocedures outlined. The nurse armacy to dictate the order. The a facsimile prescription, files into the procedure indicated second nurse during the shift by will double check/verify that complete and accurate then right side of the "red line".	F 75	5		
	labeling on 1/15/20 Parkers Way neight practical nurse (LP a tuberculin medicatest(TST) was ope expiration date of was hand written of	for medication storage and 020 at 10:42 a.m. on the aborhood with licensed (N)-A stated an opened vial of ation used for tuberculosis skin ned on 10/23/2019 with an 11/22/2019. This information in the vial and was found in the ator. LPN-A stated Parkers				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245350	B. WING		01	C / 16/2020	
NAME OF PROVIDER OR SUPPLIER ST BENEDICTS SENIOR COMMUNITY					STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 755	Way rarely admitt the residents wou one of the two she determines if som immune response TB (tuberculosis a disease that main Tuberculosis is a that are spread the person. If not treacan be fatal). LPN available for staff LPN-A immediate medication in a manager (NM)-A process to review expiration date. Five done on the niprovide the frequency refrigerator was considered with administration. Not should write open opened medication shadministration. Not should write open opened medication depend on the typical staff would the staff would the manufacturers and the staff would the manufacturers.	led residents from the hospital, ald typically be admitted from our stay units. The TST test become has developed an extended to the bacterium that causes a potentially serious bacterial ally affects the lungs. disease caused by the bacterial arough the air from person to sted properly, the TB disease I-A stated the medication was to administer to residents. By disposed of the expired sedication destruction container. If the TB skin test was in	F 7	755			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245350	B. WING _			C / 16/2020
NAME OF PROVIDER OR SUPPLIER ST BENEDICTS SENIOR COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTH SAINT CLOUD, MN 56304	•	10,2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 755	30 days after openi	ge 16 ng and was not expired and tag. RN-C stated that is the	F 75	55		
	Review of policy titl Long Term Care" d date of 12/2019 ind administered by qui monitoring of the re medication adminis administered in a til in a way to allow for administering medication adminis process for residen Further the policy in outdated or deterior available for use in expiration date/bey package/container. medication should I Original manufacture.	ed " Medication Guidelines- ated 4/2018 with a review icated medications are alified personnel who perform esident's response to stered. Medications are to be mely manner, accurately and maximum benefit. Personnel cations practice safe stration, including the correct t identification. Indicated no discontinued, reated medications are this facility. Additionally, check				
	policy lacked docur process to check for Food Procurement, CFR(s): 483.60(i)(1) §483.60(i) Food sat The facility must -	ration date if applicable. The mentation on the facility or outdated medications. Store/Prepare/Serve-Sanitary)(2)	F 81	2		2/24/20

CLIVILI	TO I OIL WEDICAILE	. & WILDICAID SLIVICES			<u> </u>	VID IVO.	0930-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		L IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245250	B. WING			(
		245350	B. WING			01/1	16/2020	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ST RENE	EDICTS SENIOR COM	MUNITY		18	810 MINNESOTA BOULEVARD SOUTHEAS	Т		
OI DENE	DIOTO OLIVIOR CON	imorri i		S	AINT CLOUD, MN 56304			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETION DATE	
TAG	REGOLATORI ORE	SCIDENTI TING INI ORWATION)	TAG		DEFICIENCY)	MAIL		
			ı					
F 812	Continued From page 17		F 8	312				
	state or local autho	rities.						
	(i) This may include	e food items obtained directly						
		rs, subject to applicable State						
	and local laws or re							
	(ii) This provision d	oes not prohibit or prevent						
		m using produce grown in facility						
		ect to compliance with applicable						
		pod-handling practices.						
		loes not preclude residents						
	from consuming to	ods not procured by the facility.						
	§483.60(i)(2) - Store, prepare, distribute and							
	serve food in accordance with professional							
	standards for food							
		NT is not met as evidenced						
	by:	The flot mot do ovidended						
		tion and interview, the facility			All Nutrition staff, including NSA-A,	will		
	failed to provide pro	provide proper hand hygiene during meal			use proper hand hygiene and glove			
	service, on the Sho	ort Stay 2nd floor South unit, for			when serving resident meals.			
	1 of 1 resident (R2)	78), during observation of						
	room tray preparati	on.			All Nutrition staff will review and sig	n off		
					on hand hygiene/glove usage.			
	Findings include:				Observational Audits will be implem	ented		
	D070la a-l!	10 0 0 0 d d d d d d d d d 0 0 0 0			weekly for one month to ensure all	41		
	_	record, dated 1/10/20,			Nutrition staff are properly following	ıne		
		s of cirrhosis of liver (scar			hand hygiene/glove usage policy.			
		y replaces healthy liver cells) mal build up of fluid in the			The Dietary Supervisor and/or design	nnee		
		derate protein calories			will report the findings of the audits			
	malnutrition.	derate protein calones			quarterly "Quality Assurance" comn			
					A determination will be made if furth			
	R278's admission I	n Minimum Data Set (MDS),			interventions are warranted as well			
		tified R278 was cognitively			determine the frequency for ongoing			
		set up only with meals.			audits.			
	During an intension	on 1/13/20 at 12:12 n m						
		on 1/13/20, at 12:12 p.m. ad only been in the facility a						
		ed she was not impressed with						
		ity. R278 stated she preferred						

	OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
	245350	B. WING			l	C 16/2020	
NAME OF PROVIDER OR SUPPLIER ST BENEDICTS SENIOR COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP O 1810 MINNESOTA BOULEVARD SO SAINT CLOUD, MN 56304				
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST B TAG REGULATORY OR LSC IDENT	E PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE	
room trays because it was dining room for meals, but cold when it arrived to the During an observation of n at 12:18 p.m. nutritional se served eight residents, sea in the Short Stay 2nd floor received chicken drumstick cheese, and beans. After room were served, NSA-A and staff brought room tray room as each was prepare the last room tray, which in R278's name and room nu observed to take a small b area, and walked to the rehands, NSA-A pulled out a container, pulled off the lid her gloved hand to grab a lettuce. NSA-A put the letture placed the lid, pulled out container, opened the lid, in tomato slice, and put the tothe lettuce. NSA-A replace another white plastic container and tomato, and drof the cheese onto the floor Using the same gloved had the shred of cheese from the it in her mouth. NSA-A replaced the bowl onto R278 removing gloves, NSA-A was table and with the same gloved and wi	the food was usually room. neal service on 1/13/20, rvices aide (NSA)-A ated in the dining room South unit. Residents ks, macaroni and residents in the dining prepared room trays, ys to the appropriate ed. As NSA-A prepared roluded a ticket with ember, NSA-A was owl from the serving frigerator. With gloved large white plastic, and reached in with handful of shredded uce in the bowl, a smaller white plastic reached in to grab a smaller white plastic reached in the lid, ploved hand, and dided cheese. NSA-A rese on top of the opped several shreds or and the countertop. Ind, NSA-A picked up the countertop and put laced the lid on the reator door, and the steam valked to the steam	F 8	12				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245350	B. WING				16/2020
NAME OF PROVIDER OR SUPPLIER ST BENEDICTS SENIOR COMMUNITY				1810	EET ADDRESS, CITY, STATE, ZIP CODE) MINNESOTA BOULEVARD SOUTHEA NT CLOUD, MN 56304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 812	plate. NSA-A used cheese and beans plate to the awaiting gloves, and washed (RN)-J picked up throom. Upon deliver to temp the food, as macaroni and chee R278 requested the removed from the ritray. When interviewed on NSA-A stated she opicked up the shred and put it in her more gloved hand to pick NSA-A stated, "I shindicated she though the chicken on the be touching food with ands. NSA-A state fingers to dish up the During an interview supervisor of nutritinutritional services utensil to serve food SNS stated, "They [serving food with hindicated the staff stremoved the gloves over. SNS stated not trained over and over and over and over and over and over staff received the gloves over. SNS stated not reasonable to staff received the gloves over. SNS stated not reasonable to staff received the gloves over some staff received the gloves over. SNS stated not reasonable to the staff staff over and over and over and over and over and over and over staff received the gloves over. SNS stated not staff received the staff received the gloves over	a utensil to add macaroni and to the plate, and brought the g tray. NSA-A removed the d her hands. Registered Nurse he tray and walked to R278's y, RN-J used a thermometer is requested, and because the se was 122 degrees, and he food be warmer, the tray was be soon and replaced with a new and the food because the se was 122 degrees, and he food because the se was 122 degrees, and he food because the se was 124 degrees, and he food because that she had dided cheese on the countertop buth, and then used the same and the food and the food and the food. The food is staff should always use and as that is standard practice. Should never be doing that he serving food, and should have immediately so, washed hands, and started for the food of the provided documentation of the provided documentation of the	F8	12			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		245350	B. WING			C / 16/2020	
NAME OF PROVIDER OR SUPPLIER ST BENEDICTS SENIOR COMMUNITY				STREET ADDRESS, CITY, STATE, Z 1810 MINNESOTA BOULEVARD SAINT CLOUD, MN 56304	IP CODE	10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 812	handling of food an food handlers are le illness out breaks." workers are require using soap and wat are contaminated in bare part of the book	ge 20 Guide, included, "Improper d poor personal hygiene of eading causes of food borne Also included, "Food service ed to thoroughly wash hands ter when ever hands or gloves including After touching any dy or hair." The Guide further y not eat or drink in the kitchen	F 8	312			

CENTERS	TOK MEDICAKE & MEDICAID SEKVICES			A FORW				
STATEMENT	OF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY				
NO HARM W	ITH ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:				
FOR SNFs AN		245350	B. WING	1/16/2020				
	OVIDER OR SUPPLIER DICTS SENIOR COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN						
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIE	NCIES						
F 640	Encoding/Transmitting Resident Assess CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing §483.20(f)(1) Encoding data. Within 7 encode the following information for ea (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's to (vi) Background (face-sheet) information formation for each of the control	requirement- days after a facilitath resident in the ments. transfer, reentry, don, if there is no action 7 days after a factor and data at the control of	ischarge, and death. Imission assessment. cility completes a resident's assessment, mation for each resident contained in the dictionaries, and that passes standardize after a facility completes a resident's assed complete MDS data to the CMS System discharge, and death. Transmission of MDS data on resident the real in the format specified by CMS or, for nat specified by the State and approved and to ensure Minimum Data Set (MDS)	a facility e MDS in a ed edits sessment, a em, at does not r a State by CMS.				
	R2 was enrolled in hospice care on 9/4/19. R2's Minimum Data Set (MDS) significant change was dated 9/10/19. Progress notes indicated R2 passed away 10/13/19. R2's MDS did not include a discharge MDS.							

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

The above isolated deficiencies pose no actual harm to the residents

If continuation sheet 1 of 2 Event ID: BR8Y11

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM		PROVIDER #	MULTIPLE CONSTRUCTION A. BUILDING:	DATE SURVEY COMPLETE:				
FOR SNFs AN	ID NFs	245350	B. WING	1/16/2020				
	OVIDER OR SUPPLIER DICTS SENIOR COMMUNITY	1810 MINNESO	STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN					
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIE	CIENCIES						
F 640	Continued From Page 1 During an interview on 1/16/20, at 10:19 a.m. MDS coordinator (RN-B) stated it was required to complete and MDS quarterly, annually, on significant change, upon discharge and upon death. RN-B confirmed a discharge MDS was not completed for R2. During an interview on 1/16/20, at 11:30 a.m. director of nursing (DON) stated MDS coordinators were required to complete an MDS upon death of a resident. The RAI manual, last updated in October 2018, directed: For Entry, Discharge and Death in Facility tracking records, information must be transmitted within 14 days of the Event Date.							

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PRINTED: 02/10/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			E SURVEY IPLETED
		245350	B. WING			01/	14/2020
NAME OF PROVIDER OR SUPPLIER ST BENEDICTS SENIOR COMMUNITY				1810 MINNES	ESS, CITY, STATE, ZIP COD OTA BOULEVARD SOUTI JD, MN 56304	PΕ	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORRE H CORRECTIVE ACTION SH 3-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	тѕ	Κ¢	00			
	ALLEGATION OF ODEPARTMENT'S ASIGNATURE AT THE PAGE OF THE CMUSED AS VERIFICATION ON SITE REVISIT OF CONDUCTED TO SUBSTANTIAL COREGULATIONS HACCORDANCE WALIFE Safety Code	OC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE CATION OF COMPLIANCE. OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. Survey was conducted by the ment Of Public Safety, State					
	Fire Marshal Division St. Benedicts Senior Compliance with the in Medicare/Medica 483.70(a), Life Safeedition of National (NFPA) Standard 1 Chapter 19 Existing IF OPTING TO US OF THE PLAN OF REQUIRED.	on. At the time of this survey, or Community was found not in e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), g Health Care. E AN EPOC, A PAPER COPY CORRECTION IS NOT			EPC	C	
ABORATORY	'DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

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.

Electronically Signed

02/07/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '			(X3) DATE SURVEY COMPLETED	
	245350	B. WING		0	I/14/2020	
NAME OF PROVIDER OR SUPPLIER ST BENEDICTS SENIOR COMMUNITY						
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE	
Health Care Fire In State Fire Marshal 445 Minnesota St., St Paul, MN 55101 By email to: FM.HC.I THE PLAN OF CODEFICIENCY MUSTOLLOWING INFO 1. A description of to correct the defice 2. The actual, or possible for corprevent a reoccurrence of the defice of the defi	pispections Division Suite 145 -5145, or PRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. Proposed, completion date. Proposed, completion date. Proposed the person rection and monitoring to ence of the deficiency. Proposed and monitoring to ence of the deficiency. Proposed the deficiency. Proposed the deficiency. Proposed the person rection and monitoring to ence of the deficiency. Proposed the person rection and monitoring to ence of the deficiency. Proposed the person rection and monitoring to ence of the deficiency. Proposed the person rection and monitoring to ence of the deficiency. Proposed the person rection and monitoring to ence of the deficiency. Proposed the person rection and monitoring to ence of the deficiency. Proposed the person rection and monitoring to ence of the deficiency. Proposed the person rection and monitoring to ence of the deficiency. Proposed the person rection and monitoring to ence of the deficiency. Proposed the person rection and monitoring to ence of the deficiency. Proposed the person rection and monitoring to ence of the deficiency. Proposed the person rection and monitoring to ence of the deficiency. Proposed the person rection and monitoring to ence of the deficiency. Proposed the person rection date.					
	Continued From particles of Educations of Ed	PROVIDER OR SUPPLIER EDICTS SENIOR COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. St. Benedicts Senior Community is a 5-story building with a full basement and an Elevator Equipment Penthouse. The building was constructed at 2 different times. The original building was constructed in 1978 and was determined to be of Type 1(332) construction. In 1997, a 2 story addition was added to the northeast that was determined to be of Type II(111) construction. Also in 2008, there was a 2 story, with no basement determined to be a Type II (III) Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as	PROVIDER OR SUPPLIER EDICTS SENIOR COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. 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WING PROVIDER OR SUPPLIER EDICTS SENIOR COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 25. Benedicts Senior Community is a 5-story building with a full basement and an Elevator Equipment Penthouse. The building was constructed in 1978 and was determined to be of Type 1(332) construction. In 1997, a 2 story addition was added to the northeast that was determined to be of Type 11(111) construction. 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AND DIAN OF CODDECTION IDENTIFICATION NUMBER.			LE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY PLETED	
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NAME OF PROVIDER OR SUPPLIER ST BENEDICTS SENIOR COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAS SAINT CLOUD, MN 56304	ST		
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K 000	department notifical capacity of 174 bed the time of the surv	nitored for automatic fire tion. The facility has a Is and had a census of 141 at	K 000			
	Fire Alarm System CFR(s): NFPA 101 Fire Alarm System A fire alarm system accordance with ar with the requirement Electric Code, and and Signaling Code acceptance, mainter available. 9.6.1.3, 9.6.1.5, NFThis REQUIREMED by: Based on document the Facility failed to Alarm System in acceptance could affect an undetermined and 9.7.5, 9.7.7, 9.7.8. Findings include: During documentation and 3:30 PM on 01 reviewed revealed:	ntation review and interview, test and maintain the Fire coordance with NFPA 70, ode, and NFPA 72, National naling Code. The deficient of 141 out of 141 residents and mount of staff and visitors.	K 345	A fire system test has been sched assure the discrepancies in the fir report matches the inventoried system components. Any changes to the in the form of additions or deletion verified and these documents will maintained in the Fire Safety book provide verification to the Fire Maintenance director and/or designee will report the findings a quarterly "Quality Assurance" com	duled to e alarm stem system is will be be < to rshall.	2/17/20
	1. Discrepancies in	n the amount of the Smoke				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
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K 345	the Fire alarm reports. The most current 10/22/2019 and the dated 9/19/2018. The standard.	tions and Heat detectors from out 2018 to the current 2019. In Fire Alarm report was dated a previous fire alarm report was This would be outside of NFPA ition was confirmed by the	K	345			
	Sprinkler System - CFR(s): NFPA 101 Spinkler System - I 2012 EXISTING Nursing homes, an construction type, a approved automati accordance with N Installation of Sprin In Type I and II commeasures are permisprinkler protection or local regulations In hospitals, sprink closets of patients of the closet does is sprinkler coverage required by NFPA Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.4.2, 19.3.5.10, 9.3.5.10,	Installation d hospitals where required by are protected throughout by an c sprinkler system in FPA 13, Standard for the akler Systems. Instruction, alternative protection in the area in specific areas where state prohibit sprinklers. Iters are not required in clothes leeping rooms where the area not exceed 6 square feet and covers the closet footprint as 13, Standard for Installation of 19.3.5.3, 19.3.5.4, 19.3.5.5,	K	351	The light fixtures will be replaced fixtures that will not obstruct the sprinklers. The fire suppression vendor will an		2/17/20

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NAME OF PROVIDER OR SUPPLIER ST BENEDICTS SENIOR COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304			
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7.2.6.2.1, The Stand Sprinkler Systems. cause a delay in expectation of the safety of 31 of the sundetermined amount of the facility tour on 01/14/2020, observealed 2 sprinkle adequate coverage wing of the 2nd floor This deficient cond Director of Mainten Portable Fire Exting CFR(s): NFPA 101 Portable Fire Exting inspected, and main NFPA 10, Standard Extinguishers. 18.3.5.12, 19.3.5.1 This REQUIREME by: Based on observation facility failed to main accordance NFPA Section 9.7.4.1 and practice could hind small fire and could undetermined amount in the safety of the standard safety of the safety of	dard for the Installation of This deficient practice could dinguishing a fire affecting the 174 patients and an unt of staff and visitors. between 8:30 AM and 3:30 PM servations and staff interview r heads that will not provide e in the sun porch on the south or. ition was confirmed by the lance. guishers guishers guishers uishers are selected, installed, intained in accordance with if for Portable Fire 2, NFPA 10 NT is not met as evidenced tion and staff interview the intain the Fire Extinguishers in 101 (2012) Life Safety Code of NFPA 10. This deficient er the extinguishment of a d affect 16 residents and an ount of visitors and staff.		potential obstruction of sprinkler annual visit. Audits will be conducted for Maintenance staff to increase at of potential scenarios of obstruct the sprinklers. The Maintenance Director and/odesignee will report the findings audits at the quarterly "Quality A committee. A determination will further interventions are warrant as to determine the frequency for audits. The monthly preventative maint checklist will be updated to inclusive accessibility of fire extinguishers Education will be conducted for maintenance staff regarding accessibilities for fire extinguishers.	g the fire the area. cessibility Audits will	2/17/20
On the facility tour	between 8:30 AM and 3:30 PM		assure compliance.	:5 tO	
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa 7.2.6.2.1, The Stant Sprinkler Systems. cause a delay in extended and safety of 31 of the undetermined amo Findings include: On the facility tour on 01/14/2020, observealed 2 sprinkle adequate coverage wing of the 2nd floor This deficient cond Director of Maintent Portable Fire Exting CFR(s): NFPA 101 Portable Fire Exting inspected, and main NFPA 10, Standard Extinguishers. 18.3.5.12, 19.3.5.1 This REQUIREME by: Based on observation facility failed to main accordance NFPA Section 9.7.4.1 and practice could hind small fire and could undetermined amount of the summary	EDICTS SENIOR COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 7.2.6.2.1, The Standard for the Installation of Sprinkler Systems. This deficient practice could cause a delay in extinguishing a fire affecting the safety of 31 of the 174 patients and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 AM and 3:30 PM on 01/14/2020, observations and staff interview revealed 2 sprinkler heads that will not provide adequate coverage in the sun porch on the south wing of the 2nd floor. This deficient condition was confirmed by the Director of Maintenance. Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the Fire Extinguishers in accordance NFPA 101 (2012) Life Safety Code Section 9.7.4.1 and NFPA 10. This deficient practice could hinder the extinguishment of a small fire and could affect 16 residents and an undetermined amount of visitors and staff. FINDINGS INCLUDE:	TOENTIFICATION NUMBER: 245350 B. WING _ SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 7.2.6.2.1, The Standard for the Installation of Sprinkler Systems. This deficient practice could cause a delay in extinguishing a fire affecting the safety of 31 of the 174 patients and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 AM and 3:30 PM on 01/14/2020, observations and staff interview revealed 2 sprinkler heads that will not provide adequate coverage in the sun porch on the south wing of the 2nd floor. This deficient condition was confirmed by the Director of Maintenance. 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TO IDENTIFICATION NUMBER: 245350 245350 245350 245350 245350 245350 245350 257001DER OR SUPPLIER 2501CTS SENIOR COMMUNITY 257001DER OR SUPPLIER 257001DER OR SUPPLIER 257001DER SENIOR COMMUNITY 257001DER SENIOR SOUTHE SAINT CLOUD, MN 56304 257001DER SENIOR CORRECT (EACH CORRECTIVE ACTION SHOLD CROSS-REFERENCED TO THE APPREDICTIVE ACTION SHOLD CROSS-REFERENCED TO THE APPREDICTION CROSS-REFEREN	PROVIDER OR SUPPLIER DICTS SENIOR COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SENIOR COMMUNITY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 58304 Continued From page 4 7.2.6.2.1, The Standard for the Installation of Sprinkler Systems. This deficient practice could cause a delay in extinguishing a fire affecting the safety of 31 of the 174 patients and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 AM and 3:30 PM on 01/14/2020, observations and staff interview revealed 2 sprinkler has been sufficient or provide adequate coverage in the sun porch on the south wing of the 2nd floor. This deficient condition was confirmed by the Director of Maintenance. Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. R 355 The Chair which was obstructing the fire extinguishers are selected in the Fire Extinguishers and STA1 interview the facility failed to maintain the Fire Extinguishers in accordance NFPA 101 (2012) Life Safety Code Section 9.7.4.1 and NFPA 10. This deficient practice could hinder the extinguishers and could affect 16 residents and an undetermined amount of visitors and staff. FINDINGS INCLUDE: A BUILDING 01 - MAIN BUILDING 01/16 (EACH COURS) STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, Mn 58304 PROVIDER OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E 10

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY PLETED
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NAME OF PROVIDER OR SUPPLIER ST BENEDICTS SENIOR COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHE SAINT CLOUD, MN 56304		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	JLD BE	(X5) COMPLETION DATE
n 01/14/2020, obs xtinguisher was ob ane. 'his deficient condi	ervations revealed the fire ostructed by a chair in memory tion was confirmed by the	K 3	The Maintenance Director and/ordesignee will report the findings audits at the quarterly "Quality A committee. A determination will further interventions are warrant as to determine the frequency for	of the ssurance" be made if ed as well	
Maintenance, Inspective doors assembly in accordance or Fire Doors and office for a country in attent rooms and soutinely inspected naintenance programications and setting possess known at demonstrates a vitten records of infaintained and are 9.7.6, 8.3.3.1 (LSC).2, 5.2.3 (2010 NF) in a REQUIREMENTY: Based on document of all fire rated door 12) Life Safety Cool. 2.1.15.4. This define spread of fire if a accordance with	ection & Testing - Doors ies are inspected and tested nce with NFPA 80, Standard Other Opening Protectives. cluding corridor doors to smoke barrier doors, are as part of the facility am. ing the door inspections and owledge, training or experience ability. nspection and testing are available for review. C) PA 80) NT is not met as evidenced intation review and staff of failed to conduct inspections is and required by NFPA 101 ide, section 7.2.1.15.2 & icient practice could allow for the doors were not maintained its rating. This could affect all		An audit of the fire rated doors conducted on January 29, 2020 condition of doors. Based on the assessment, it was determined doors will be replaced and five or repaired. Repairs to doors will be conducted and replacement docarrive the week of March 23rd.	to assess is that four doors be e ors will	3/23/20
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa n 01/14/2020, obsections of Maintenance, Inspection of Maintenance, Inspective doors assembly in accordance or Fire Doors and of Ion-rated doors, in attent rooms and section of Maintenance programment of the pro	DOVIDER OR SUPPLIER ICTS SENIOR COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 in 01/14/2020, observations revealed the fire xtinguisher was obstructed by a chair in memory ane. In this deficient condition was confirmed by the birector of Maintenance. In this deficient condition was confirmed by the birector of Maintenance. In this deficient condition was confirmed by the birector of Maintenance. In the service of th	DOWNDER OR SUPPLIER ICTS SENIOR COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR INTERPOLATION OF LSC IDENTIFYING INFORMATION Continued From page 5 In 01/14/2020, observations revealed the fire extinguisher was obstructed by a chair in memory ane. This deficient condition was confirmed by the Director of Maintenance. In Sepection & Testing - Doors FER(s): NFPA 101 Maintenance, Inspection & Testing - Doors For Fire Doors and Other Opening Protectives. In For Fire Doors and Opening Protectives. In For Fire Doors and In For Fire Protectives. In For Fire Doors and In For Fire Protectives. In For	Description Number: 245350 245350 245350 245350 245350 245350 245350 245350 245350 245350 245350 245350 245350 257262 2	245350 245350 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUP, MP 56304 SUMMARY STATEMENT OF DEFICIENCIES SAINT CLOUP, MP 56304 PROVIDERS PLAN OF CORRECTION FROM DEFICIENCY TAG TO 1/1/4/2020, observations revealed the fire kinguisher was obstructed by a chair in memory ine. Stontinued From page 5 In 0/1/4/2020, observations revealed the fire kinguisher was obstructed by a chair in memory ine. Stontinued From page 5 In 0/1/4/2020, observations revealed the fire kinguisher was obstructed by a chair in memory ine. Stontinued From page 5 In 0/1/4/2020, observations revealed the fire kinguisher was obstructed by a chair in memory ine. K 355 The Maintenance Director and/or designee will report the findings of the audits at the quarterly "Quality Assurance" committee. A determination will be made if further interventions are warranted as well as determined that seal determined and in the fire requency for ongoing audits. K 761 Maintenance, Inspection & Testing - Doors ire doors and Other Opening Protectives, lon-rated doors, including corridor doors to attent rooms and smoke barrier doors, are putinely inspected as part of the facility maintenance program. Individuals performing the door inspections and sating possess knowledge, training or experience hat demonstrates ability. Written records of inspection and testing are maintained and are available for review. 9,7.6, 8.3.3.1 (LSC) 2, 5.2.3 (2010 NFPA 80) his REQUIREMENT is not met as evidenced yellow for inspections fall fire rated doors and required by NFPA 101 12) Life Safety Code, section 7.2.1.15.2.8 An audit of t

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		I DENTIFICATION NUMBER		MULTIPLE CONSTRUCTION JILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER ST BENEDICTS SENIOR COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CO 1810 MINNESOTA BOULEVARD SOU SAINT CLOUD, MN 56304	ODE		
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K 901	and 3:30 PM on 01 review revealed the the doors from the 07/01/2019 of the f This deficient cond Facility Maintenand Fundamentals - Bu CFR(s): NFPA 101 Fundamentals - Bu Building systems a 1 through 4 require Categories are determined the control of the control	tion review between8:30 AM /14/2020, documentation ere were no repairs made to annual inspections dated ire rated doors. ition was confirmed by the ce Director. idding System Categories re designed to meet Category ements as detailed in NFPA 99. ermined by a formal and assessment procedure fied personnel.	K 76	be performed annually by tra repair/replacement will be de acted upon. Education will b by trained facilities staff to in maintenance department as evaluation of doors and repa The maintenance director as designee will report the finding quarterly "Quality Assurance	etermined and be performed anclude entire it relates to airs. and/or angs at the	2/17/20	
	by: Based on docume interview, the facilit systems are design through 4 requirem Categories are det documented risk a performed by quali	entation review and staff ty failed to inspect the building need to meet Category 1 ments as detailed in NFPA 99. The ermined by a formal and seessment procedure fied personnel. The deficient ct all residents, staff and an out of visitors.		A risk assessment audit had completed and entered into order system. Going forward the risk asse will be completed as required. The maintenance director and designee will report the find quarterly "Quality Assurance."	ssment audit ed by NFPA.		

245350 B. WING 01/1	4/2020
243330 0. (1/1)	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304	
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During documentation review between 8:30 AM and 3:30 PM on 01/14/2020, documentation review and staff interview revealed the required risk assessment NFPA 99 was incomplete at the time of the survey. This deficient condition was confirmed by the Facility Maintenance Director.	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 30, 2020

Administrator St Benedicts Senior Community 1810 Minnesota Boulevard Southeast Saint Cloud, MN 56304

Re: State Nursing Home Licensing Orders

Event ID: BR8Y11

Dear Administrator:

The above facility was surveyed on January 13, 2020 through January 16, 2020 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 <u>only a suggestion</u> 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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

St Benedicts Senior Community January 30, 2020 Page 2

"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:

Kathleen Lucas, Unit Supervisor
St. Cloud B 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: kathleen.lucas@state.mn.us

Phone: (320) 223-7343 Fax: (320) 223-7348

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

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

Please feel free to call me with any questions.

Sincerely,

Towards Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health St Benedicts Senior Community January 30, 2020 Page 3

Licensing and Certification Program Program Assurance Unit Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY DMPLETED	
	00774		B. WING		01/1	6/2020
NAME OF	PROVIDER OR SUPPLIER		1	STATE, ZIP CODE	1 01/1	0/2020
ST BENI	EDICTS SENIOR COM	MIINITY	NESOTA BO	OULEVARD SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	Department's staff	20, surveyors of this visited the above provider and tion orders are issued.				
	The following comp substantiated:	laints were found to be				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

02/07/20 **Electronically Signed**

TITLE

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			E SURVEY PLETED		
		00774	B. WING			C 16/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE. ZIP CODE		
		1810 MIN		JLEVARD SOUTHEAST		
ST BENE	EDICTS SENIOR COM	MUNITY SAINT C	LOUD, MN 56	304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	H5350091C. No lice H5350092C. No lice H5350093C. No lice	ensing orders issued. ensing orders issued. ensing orders issued. ensing orders issued.				
	the State Licensing federal software. To assigned to Minnes Nursing Homes. The appears in the far let Tag." The state statisted in the "Summ column and replace the correction order the findings which a statute after the state as evidence by." For	nent of Health is documenting Correction Orders using ag numbers have been tota state statutes/rules for the assigned tag number teft column entitled "ID Prefix tatute/rule out of compliance is the "To Comply" portion of the "To Comply" portion of the state tement, "This Rule is not met tollowing the surveyors findings Method of Correction and trection.				
	receipt of State lice the Minnesota Departmentional Bullet http://www.health.si obul.htm The State delineated on the a Department of Hea you electronically. is necessary for State enter the word "correct. You must then State licensure processors."	in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health

STATE FORM BR8Y11 If continuation sheet 2 of 24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:) DATE SURVEY COMPLETED			
	00774		B. WING		C 01/16/2020	
NAME OF F	PROVIDER OR SUPPLIER		DRESS. CITY. S	STATE, ZIP CODE	01/10/2020	
ST BENE	EDICTS SENIOR COM	MIINIIY	NESOTA BO	ULEVARD SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
2 000	Continued From pa	ge 2	2 000			
	Minnesota Department of Health.					
21010	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA IS NO REQUIREM! CORRECTION FOR MINNESOTA STATE MN Rule 4658.0610 Requirements-Eating. A food only in areas of dining. An employed designated if consucould cause contain equipment, or utens apply to cooks or of the cook who test the palatability.	N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF R VIOLATIONS OF E STATUTES/RULES. O Subp. 6 Dietary Staffing. Il employees must consume esignated for employee ed dining area must not be ming food in that location nination of other food, sils. This subpart does not ther persons designated by the food for flavor and	21010		2/24/20	
	by: Based on observati failed to provide pro service, on the Sho	on and interview, the facility oper hand hygiene during meal rt Stay 2nd floor South unit, for '8), during observation of on.		All Nutrition staff, including NSA-A, w use proper hand hygiene and glove u when serving resident meals. All Nutrition staff will review and sign	sage	
	Findings include:	ecord, dated 1/10/20, s of cirrhosis of liver (scar		on hand hygiene/glove usage. Observational Audits will be implement weekly for one month to ensure all Nutrition staff are properly following thand hygiene/glove usage policy.	nted	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Y
			A. BOILDING	•		
		00774	B. WING		01/16/2020)
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
		1810 MIN	NESOTA BO	OULEVARD SOUTHEAST		
ST BENE	EDICTS SENIOR COM	MUNITY SAINT CL	LOUD, MN 5	6304		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION (X5	5)
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		PLETE TE
21010	21010 Continued From page 3		21010			
	tissue that gradually replaces healthy liver cells) with ascites (abnormal build up of fluid in the abdomen) and moderate protein calories malnutrition. R278's admission Minimum Data Set (MDS), dated 1/16/20, identified R278 was cognitively intact, and required set up only with meals. During an interview on 1/13/20, at 12:12 p.m. R278 stated she had only been in the facility a short time, but stated she was not impressed with the food at the facility. R278 stated she preferred room trays because it was taxing to go to the dining room for meals, but the food was usually cold when it arrived to the room. During an observation of meal service on 1/13/20, at 12:18 p.m. nutritional services aide (NSA)-A served eight residents, seated in the dining room in the Short Stay 2nd floor South unit. Residents received chicken drumsticks, macaroni and cheese, and beans. After residents in the dining room were served, NSA-A prepared room trays, and staff brought room trays to the appropriate room as each was prepared. As NSA-A prepared the last room tray, which included a ticket with R278's name and room number, NSA-A was observed to take a small bowl from the serving area, and walked to the refrigerator. With gloved hands, NSA-A pulled out a large white plastic container, pulled off the lid, and reached in with her gloved hand to grab a handful of shredded lettuce. NSA-A put the lettuce in the bowl, replaced the lid, pulled out a smaller white plastic container, opened the lid, reached in to grab a tomato slice, and put the tomato slice on top of the lettuce. NSA-A replaced the lid, pulled out another white plastic container, opened the lid, reached in to grab a tomato slice, and put the tomato slice on top of the lettuce in with the same gloved hand, and			The Dietary Supervisor and/or d will report the findings of the aud quarterly "Quality Assurance" co A determination will be made if f interventions are warranted as w determine the frequency for ong audits.	its at the mmittee. urther rell as to	

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STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. BOILDING.		С	
		00774	B. WING		1	6/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST BENEDICTS SENIOR COMMUNITY			NESOTA BO OUD, MN 50	ULEVARD SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21010	grabbed a handful of sprinkled the shred lettuce and tomato, of the cheese onto Using the same glot the shred of cheese it in her mouth. NS/container, closed the placed the bowl onto removing gloves, Notable and with the sound to the stocken drums in plate. NSA-A used cheese and beans plate to the awaiting gloves, and washed (RN)-J picked up the room. Upon deliver to temp the food, as macaroni and cheese R278 requested the removed from the room. When interviewed on the picked up the shred and put it in her moderate gloved hand to picked up the shred and put it in her moderate gloved hand to picked up the shred and put it in her moderate gloved hand to picked up the shred and put it in her moderate gloved hand to picked up the shred and put it in her moderate gloved hand to picked up the shred and put it in her moderate gloved hand to picked up the shred and put it in her moderate gloved hand to picked up the shred and put it in her moderate gloved hand to picked up the shred and put it in her moderate gloved hand to picked up the chicken on the betouching food whands. NSA-A state fingers to dish up the distribution of nutritic purpose.	of shredded cheese. NSA-A ded cheese on top of the and dropped several shreds the floor and the countertop. Wed hand, NSA-A picked up the from the countertop and put A-A replaced the lid on the perefrigerator door, and to R278's tray. Without SA-A walked to the steam same gloved hand, picked up ticks and placed them on a sequence of the late, and brought the gray. NSA-A removed the did her hands. Registered Nurse the tray and walked to R278's y, RN-J used a thermometer of sequested, and because the se was 122 degrees, and the food be warmer, the tray was shown and replaced with a new and the food the same of the countertop outh, and then used the same out the late of the hand used a fork to put plate because she shouldn't hen serving, even with gloved the late of	21010			
	nutritional services	onal services (SNS) stated staff should always use a d as that is standard practice.				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY	
7.110 1 27.11	or correction.	BERTIN IO/THORNOLISETT.	A. BUILDING:				
		00774	B. WING			6/ 2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ST BENE	EDICTS SENIOR COM	IMUNITY	NESOTA BO .OUD, MN 50	ULEVARD SOUTHEAST 6304			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
21010	SNS stated, "They [serving food with h goes in their mouth indicated the staff's removed the gloves over. SNS stated in trained over and own handwashing, and education staff recent rec	should never be doing that hands]." SNS stated, "Nothing I," while serving food, and should have immediately is, washed hands, and started utritional services staff are rere about glove use and provided documentation of the leive. Ity's undated Nutrition Services Guide, included, "Improper Id poor personal hygiene of leading causes of food borne Also included, "Food service led to thoroughly wash hands there when ever hands or gloves including After touching any left of yor hair." The Guide further yor hair. The Guide further you have all procedures to do hygiene during meal service SNS could educate all the SNS could develop to the surface ongoing your those results to the quality	21010	BEHOLENOT)			
21530	•	0 A.B.C Drug Regimen Review	21530			2/24/20	
	A. The drug regim	en of each resident must be					

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COM	LETED
		00774	B. WING			C 1 6/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST BENI	EDICTS SENIOR COM	IMUNITY	NESOTA BO .OUD, MN 50	ULEVARD SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T	ULD BE	(X5) COMPLETE DATE
21530	currently licensed by This review must by Appendix N of the Street Surveyor Procedure Requirements in Lot the Department of Health Care Finance This standard is in available through the system. It is not sure B. The pharma irregularities to the and the attending properties to the and the attending properties. For purpon' means the areport and the sign of nursing services. C. If the attend with the pharmacist of provide adequate pharmacist believes being adversely after the matter to diff the medical direct physician. If the method the physician does not must be referred for assessment and as by part 4658.0070, the medical direct must refer the matter the matter the matter the medical direct must refer the matter the matter the matter the medical direct must refer the matter the matter the medical direct must refer the matter the matter the matter the matter the matter the medical direct must refer the matter th	nonthly by a pharmacist by the Board of Pharmacy. Be done in accordance with State Operations Manual, less for Pharmaceutical Service ong-Term Care, published by Health and Human Services, bing Administration, April 1992. Corporated by reference. It is the Minitex interlibrary loan abject to frequent change. The must report any director of nursing services only sician, and these reports in by the time of the next conner, if indicated by the arposes of this part, "acted compared to rejection of the ing or initialing by the director and the attending physician. In the pharmacist must the medical director for review the inguity of life is sected, the pharmacist must the medical director for review tor is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter or review to the quality securance committee required. If the attending physician is for, the consulting pharmacist for the consulting pharmacist for the directly to the quality securance committee.	21530			

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Minnesota Department of Health STATE FORM

NAME OF PROVIDER OR SUPPLIER ST BENEDICTS SENIOR COMMUNITY 1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304 [X4) ID SUMMARY STATEMENT OF DEFICIENCIES SAINT CLOUD, MN 56304 21530 Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and documentation, the facility failed to ensure medication orders were clarified for 1 of 5 residents (R48) reviewed for unnecessary medications, who had two Maalox as needed orders. Additionally, the facility failed to ensure medication from 1 of 6 medication rooms in Parkers Way neighborhood was removed and not available for use once expired. R48's quarterly Minimum Data Set (MDS), dated 11/12/19, indicated R48 had short term and long term memory issues. R48 required extensive assist with transfers, dressing, personal hygiene, and eating. R48's Diagnosis Report, printed 1/15/20, included a diagnosis of gastro-esophageal reflux disease (GERD). R48's Order Summary Report, identified 2 current as needed (PRN) orders for Maalox both prescribed on 7/15/19. 1) Maalox regular strength suspension 200-200-200 mg/5 ml. Give 10 cc by mouth every 2 hours as needed for indigestion,		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE COMPI	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304						С	
SUMMARY STATEMENT OF DEFICIENCES SAINT CLOUD, MN 56304 PREFIX TAGS SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAGS PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE			00774	B. WING		01/1	6/2020
XAI, ID XAI,	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
21530 Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and documentation, the facility failed to ensure medication orders were clarified for 1 of 5 residents (R48) reviewed for unnecessary medications, who had two Maalox as needed orders. Additionally, the facility failed to ensure medication from 1 of 6 medication rooms in Parkers Way neighborhood was removed and not available for use once expired. R48's quarterly Minimum Data Set (MDS), dated 11/12/19, indicated R48 had short term and long term memory issues. R48 required extensive assist with transfers, dressing, personal hygiene, and eating. R48's Order Summary Report, identified 2 current as needed (PRN) orders for Maalox both prescribed on 7/15/19, 1) Maalox regular strength suspension 200-200-200 mg/5 ml. Give 10 cc by mouth every 2 hours as needed for indigestion,	ST BENE	EDICTS SENIOR COM	MIINITY				
This MN Requirement is not met as evidenced by: Based on observation, interview, and documentation, the facility failed to ensure medication orders were clarified for 1 of 5 residents (R48) reviewed for unnecessary medications, who had two Maalox as needed orders. Additionally, the facility failed to ensure medication from 1 of 6 medication rooms in Parkers Way neighborhood was removed and not available for use once expired. Findings include: Findings include: Findings include: R48's quarterly Minimum Data Set (MDS), dated 11/12/19, indicated R48 had short term and long term memory issues. R48 required extensive assist with transfers, dressing, personal hygiene, and eating. R48's Order Summary Report, identified 2 current as needed (PRN) orders for Maalox both prescribed on 7/15/19. 1) Maalox regular strength suspension 200-200-20 mg/5 ml. Give 10 cc by mouth every 2 hours as needed for indigestion,	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
Review of R48's Medication Administration Records (MAR) since the Maalox order date of 7/15/19, identified R48 received 20 cc of Maalox on 7/15/19 at 10:11	21530	This MN Requirements: Based on observation documentation, the medication orders or residents (R48) reviewed medications, who horders. Additionally medication from 1 or Parkers Way neighta available for use or Findings include: R48's quarterly Min 11/12/19, indicated term memory issue assist with transfers and eating. R48's Diagnosis Rea diagnosis of gasti (GERD). R48's Order Summas needed (PRN) or prescribed on 7/15/suspension 200-20 mouth every 2 hourn nausea. 2) Maalox 200-200-20 mg/5 m 2 hours as needed orders did not directly cross or visa versa. Review of R48's More Records (MAR) sin 7/15/19, identified Filmes. R48's July 20 to the medication of the cords (MAR) sin 7/15/19, identified Filmes. R48's July 20 to the medication of the cords (MAR) sin 7/15/19, identified Filmes. R48's July 20 to the medication of the cords (MAR) sin 7/15/19, identified Filmes. R48's July 20 to the medication of the cords (MAR) sin 7/15/19, identified Filmes. R48's July 20 to the medication of the cords (MAR) sin 7/15/19, identified Filmes. R48's July 20 to the medication of the cords (MAR) sin 7/15/19, identified Filmes. R48's July 20 to the medication of the medication of the cords (MAR) sin 7/15/19, identified Filmes. R48's July 20 to the medication of the medica	ent is not met as evidenced ion, interview, and facility failed to ensure were clarified for 1 of 5 iewed for unnecessary and two Maalox as needed to the facility failed to ensure of 6 medication rooms in borhood was removed and not nee expired. imum Data Set (MDS), dated R48 had short term and long as. R48 required extensive as, dressing, personal hygiene, export, printed 1/15/20, included ro-esophageal reflux disease ary Report, identified 2 current orders for Maalox both 19. 1) Maalox regular strength 0-20 mg/5 ml. Give 10 cc by as as needed for indigestion, regular strength suspension nl. Give 20 cc by mouth every for indigestion, nausea. The at when to give 10 cc versus 20 edication Administration ce the Maalox order date of R48 received Maalox PRN 2 019 MAR identified R48	21530	1/15/2020, leaving only one availanceded order. As noted within the statement of deficiency, the expirit tuberculin was immediately dispositive orders. A process was identified to review stock medicate expiration/beyond use dates. This will be completed monthly. Random chart audits will be computered that orders are being clariparameters for use and/or eliminal potentially duplicative orders. Randometrially duplicative orders. Randometrially duplicative orders. Randometrially duplicative orders. Randometrially duplicative orders. The Director of Nursing and/or dewill report the findings of the audit quarterly "Quality Assurance" con and determine if further interventimetrials as well as to determine	able as e ed vial of sed on on on the r the rameters ntially s ions for s process oleted to fied for ation of ndom leted to esignee ts at the nmittee ons are	

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STATE FORM BR8Y11 If continuation sheet 8 of 24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00774	B. WING			C 01/16/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
ST RENI	EDICTS SENIOR COM	MIINITY 1810 MIN	NESOTA BOU	JLEVARD SOUTHEAST			
JI BEN	LDICTS SEIVICK COM	SAINT C	_OUD, MN 56	304			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	TION SHOULD BE COMPLET THE APPROPRIATE DATE		
21530	Continued From pa	ge 8	21530				
	a.m. R48's August received 20 cc of Ma.m. R48's record la received 20 cc dose During an interview licensed practical nashe would administ reviewed R48's Jan R48 had indigestion receive 20 cc of Masecond order for Masecond	2019 MAR indicated R48 laalox on August 24th at 9:34 acked the reason R48 e versus the 10 cc dose. on 1/15/20, at 1:06 p.m. urse (LPN)-D was asked how er Maalox to R48. LPN-D augry 2020 MAR and stated if n or nausea, R48 would allox. When directed to R48's aalox 10 cc, LPN-D stated "Ohn order for 10 cc as well. she would give the 10 cc first, if indigestion or nausea was en probably administer 20 cc. as generally have perimeters erent dosages ordered, but have perimeters for the					
	consulting pharmac catch dosage discrereviews. CP-A state missed. CP-A state physician to clarify cc or 20 cc PRN. The facility's policy 10/11, directed phy the staff RN or LPN LPN, or health infor accordance with prewill call/fax the pharmacist writes a and fills the prescripthe night nurse (or corder was received)	on 1/15/20, at 12:06 p.m. the sist (CP)-A stated he try's to epancies during is monthly ed R48's Maalox order was d he would recommend the the Maalox order for either 10. Physician Orders, dated sician orders are obtained by I and transcribed by the RN, mation specialist in ocedures outlined. The nurse macy to dictate the order. The facsimile prescription, files otion. The procedure indicated second nurse during the shift will double check/verify that complete and accurate then					

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Minnesc	ota Department of He	aitti				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
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		00774	B. WING			6/2020
		00774			01/1	6/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1810 MINI	NESOTA BO	ULEVARD SOUTHEAST		
ST BENE	EDICTS SENIOR COM	MUNITY SAINT CL	OUD, MN 5	6304		
(VA) ID	CLIMMADV CTA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX		'MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIES	PRIATE	DATE
				DEFICIENCY)		
21530	Continued From pa	ne 0	21530			
21000	Continued i Tom pa	ge 3	21000			
	initial and date the	right side of the "red line".				
		for medication storage and				
		20 at 10:42 a.m. on the				
	, , ,	borhood with licensed				
		N)-A stated an opened vial of				
		tion used for tuberculosis skin				
		ned on 10/23/2019 with an				
		1/22/2019. This information				
		the vial and was found in the				
		tor. LPN-A stated Parkers				
		d residents from the hospital,				
		typically be admitted from				
		t stay units. The TST test				
		one has developed an				
		o the bacterium that causes				
		ootentially serious bacterial				
	disease that mainly					
		sease caused by the bacteria bugh the air from person to				
		ed properly, the TB disease				
		A stated the medication was				
		administer to residents.				
		disposed of the expired				
		dication destruction container.				
		the TB skin test was in				
	circulation for nearly					
	on our district from	y 2 monaio.				
	During interview on	1/16/2020, at 8:17 a.m. nurse				
		dicated there was no formal				
	process to review stock medications for					
		ther NM-A stated this should				
		nt shift. NM-A was unable to				
		cy of when the med				
		ecked for expired medications.				
		tated the expiration date on				
		uld be reviewed prior to				
		-A stated the nursing staff				
		late and expiration date on				
		s. The expiration date would				

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:				LETED
		A. DOILDING.		_	
	00774	B. WING		04/4	
	00774	D. WING		01/1	6/2020
NAME OF PROVIDER OR SUPPLIER	R STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST BENEDICTS SENIOR CO	MMIINITY 1810 MIN	NESOTA BO	ULEVARD SOUTHEAST		
OT BENEDIOTO GENIOR GO	SAINT CL	OUD, MN 5	6304		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530 Continued From p	age 10	21530			
•	depend on the type of medication, generally 28				
registered nurse (were located in th room. RN-C state and the staff woul the manufacturers date opened and 30 days after open hand written on th facilities current p Review of policy t Long Term Care" date of 12/2019 in administered by q monitoring of the medication admin administered in a in a way to allow f administering med medication admin process for reside Further the policy outdated or deteri available for use i expiration date/be package/containe medication should Original manufact the includes: Medication name Strength Quantity Accessory instruct Lot name and exp policy lacked doce	tled " Medication Guidelines- dated 4/2018 with a review dicated medications are ualified personnel who perform resident's response to istered. Medications are to be timely manner, accurately and or maximum benefit. Personnel dications practice safe istration, including the correct nt identification. indicated no discontinued, orated medications are n this facility. Additionally, check yond use date on r. The policy indicated stock I be labeled with the following: urer or pharmacy applied label				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	DATE SURVEY COMPLETED		
	00774				C 01/16/2020
	PROVIDER OR SUPPLIER	MUNITY 1810 MIN	, ,	STATE, ZIP CODE BULEVARD SOUTHEAST 6304	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	director of nursing (review and revise p pharmacy reviews a policies related to n to check for expirat designee could dev and develop a mon pharmacy reviews a being acted upon a being properly dispons assurance committe measures to ensure	THOD OF CORRECTION: The (DON) or designee could olicies and procedures for and irregularities including nedication monitoring systems ion. The director of nursing or elop a system to educate staff itoring system to ensure are timely, irregularities are nd expired medications are osed of. The quality ee could monitor these	21530		
21805	Residents of HC Farsum Subd. 5. Courteour residents have the courtesy and resperent employees of or perhealth care facility. This MN Requirement by: Based on observation review, the facility farsident was provided who waited for 33 manswered. In additional a catheter bag control of the courtes of the cou	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a ent is not met as evidenced on, interview and document ailed to ensure timely care of a ed for 1 of 2 residents (R112) ninutes for the call light to be ion, the facility failed to ensure aining urine was concealed 1 of 3 residents (R73)	21805	R112's care plan was updated on 1/14/2020 indicating for staff to stay wit resident while on the toilet. R73's urinal catheter bag was covered with a privac bag on 1/16/2020. Staff will receive education on the importance of maintaining resident's	у

Minnesota Department of Health

STATE FORM BR8Y11 If continuation sheet 12 of 24

STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE :	
		00774	B. WING		C	
		00774	D. WING		01/1	6/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
ST BENI	EDICTS SENIOR COM	MIINITY	NESOTA BC OUD, MN 5	OULEVARD SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 12	21805			
21805	Findings include: R112's admission Mated 12/29/19, ide cognitive impairmed assistance with active R112's fall Care Ard 12/26/19, identified goes to stand, walk and when transferre stabilize. Had a hist facility when attempt R112's care planned intervone staff to transfer assistance of one splan also indicated related to history of call light, had poor self-transferred. Caincluded call light, riself-transfers was of fractures and injuried During interview on member (FM)-A statoilet for an extendentialized both the bat pendant worn on a stated the family had facility on 1/12/20, of they (the facility we R112 had the call light).	Minimum Data Set (MDS) ntified R112 had moderate nt and required extensive vities of daily living (ADLs) ea Assessment (CAA) dated R112 was unsteady when , turn, move on and off toilet, ed, needed staff assist to cory of falling, with a fall in oted to self-transfer. Evised 12/15/19, identified re deficit related to weakness, entions included assistance of r with wheeled walker and taff with toileting needs. Care R112 had a potential for injury falls, did not consistently use eafety awareness, and are planed interventions ept within reach in bedroom, utilize call light, R112 had sks and consequences of liscussed which included falls, es up to and including death. 01/13/20, at 1:08 p.m. family ated R112 had been left on the ed period of time, R112 had chroom pull cord in addition to chain around the neck. FM-A and received phone call from caller had apologized, stated are in the wrong) then stated ght on for over 30 minutes, and from the toilet to the	21805	dignity, including responding to reneeds within a timely manner. State also receive education on covering catheter drainage bags when in planeas. A standard task has been on within our electronic medical recording to the readily assigned as a remistaff to cover urinary drainage bag privacy bag, for those residents were a urinary catheter. Random observational audits will completed to assure that residents use a urinary catheter drainage bathat bag within a privacy bag. The will be conducted weekly for one of the monthly until the next "Quarter Assurance" committee. The Director of Nursing and/or de will report the findings of the audit quarterly "Quality Assurance" com A determination will be made if fur interventions are warranted as we determine the frequency for ongoinaudits.	iff will g urinary ublic created rd which nder for gs with a hom use be s whom ag, have se audits month, erly signee s at the mittee. rther ill as to	

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STATE FORM BR8Y11 If continuation sheet 13 of 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00774	B. WING		 	C
		00774	B. WING		01/	16/2020
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST BENE	EDICTS SENIOR COM	MUNITY	NNESOTA BO LOUD, MN 56	ULEVARD SOUTHEAST 3304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
21805	O5 Continued From page 13		21805			
	stated R112 require concerned there co potential for injury. FM-A, was crying a me alone and didn't on for an hour". A progress note darupdated family regamorning with reside	ere no injuries. FM-A further ed assistance to transfer, was uld have been a fall with a R112 was seated next to nd repeatedly stated "they left tome back, I had the lights ted 1/12/2020, identified arding toileting situation in the ent. No further concerns were				
	morning with resident. No further concerns were expressed. When interviewed on 1/15/20, at 2:08 p.m. registered nurse (RN)-A stated R112 had been left on the toilet alone, the care plan had not stated R112 required staff to stay in the bathroom, both the bathroom call light and R112's pendant call light had been on for 33 minutes. R112 required assistance of one staff and wheeled walker to transfer.					
	stated R112 was le according to call lig light and pendant cominutes, facility was had independently to RN-B further stated	on 1/16/20, at 9:18 a.m. RN-B ft on the toilet alone, ht report the bathroom call all light had been on for 33 s not sure at what point R112 transferred to the wheelchair. It this was poor customer hould have been answered by utes.	,			
	RN-B for R112 prin had used the penda 9:40 a.m. with penda 10:14 a.m., call ligh 14 seconds. RN-B utilized the pendant	evice Activity Report with ted 1/16/20, identified R112 ant call light on 1/12/20, at lant being cleared by staff at t had been on for 34 minutes stated that was when R112 to be placed on the toilet. On m. R112 utilized pendant call				

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STATE FORM BR8Y11 If continuation sheet 14 of 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
				c
00774	B. WING			16/2020
NAME OF PROVIDER OR SUPPLIER STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ST BENEDICTS SENIOR COMMUNITY	INESOTA BOUI LOUD, MN 563	LEVARD SOUTHEAST 04		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
light then at 10:37 a.m. R112 utilized bathroom call light which had been on for 29 minutes 51 seconds. Pendant call light was cleared by staff at 11:00 a.m., bathroom call light was cleared by staff at 11:06 a.m. which had been on for 33 minutes 3 seconds. RN-B stated this was not acceptable customer service. Policies regarding call lights was requested, received a policy Call Light - Interruption of Service which did not address answering of call lights. R73 R73's significant change MDS dated 12/5/19, identified R73 had severe cognitive impairment and required extensive assistance with care. R73's Urinary/Indwelling Catheter CAA dated 12/7/19, identified R73 had an indwelling catheter in place. During observation on 1/13/20, at 12:25 p.m. urinary catheter bag with urine inside was hanging uncovered below R73's Broda chair (specialty reclining wheelchair) at table in dining room. At 5:48 p.m. catheter bag containing urine was hanging below Broda chair in dining room uncovered. When observed on 1/14/20, at 8:34 a.m. Urinary catheter bag containing urine was hanging uncovered below Broda chair in the dining room. At 1:48 p.m. R73 was in room with urinary catheter bag containing urine hanging below Broda chair visible from hallway. At 3:15 p.m. R73 continued to have urinary catheter bag	21805			

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STATE FORM BR8Y11 If continuation sheet 15 of 24

	AND BLAN OF CORRECTION . IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С	
		00774	B. WING		01/	16/2020	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ST BENE	EDICTS SENIOR COM	IMILINILY	LOUD, MN 5	OULEVARD SOUTHEAST 6304			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
21805	Continued From pa	age 15	21805				
	chair visible from h	allway.					
	When observed on 1/15/20, at 10:42 a.m. R73 was in room with urinary catheter bag which contained urine was hanging below Broda chair uncovered, visible from hallway.						
	When interviewed on 1/15/20, at 10:51 a.m. nursing assistant (NA)-A stated was just going to grab a dignity bag for R73, dignity bags were to be in place to protect the dignity of the residents.						
	When observed at 1/15/20, at 12:07 p.m. R73 was in common area with urinary catheter bag hanging below Broda chair uncovered and visible. At 12:32 p.m. R73 was in the dining room no dignity bag in place, catheter bag containing urine visible. At 2:00 p.m. urinary catheter bag continued to be uncovered and visible from hallway. When interviewed on 1/15/20, at 2:08 p.m. RN-A stated urinary catheter bags were to have covers for resident dignity.						
	FM-A stated R73 w before dementia pr	view on 1/16/20, at 9:14 a.m. vas a very dignified person rogressed, R73 would be upset o know other people could see heter bag.					
	stated privacy bags	on 1/16/20, at 9:29 a.m. RN-B s were to be in place for all eter drainage bags for their					
	Bed revised 6/2019	olicy - Long Term Care/Swing 9, identified all staff were to to maintain and enhance ity.					

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STATEMENT OF DEFICIENCIES (X1)

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '			SURVEY
			A. BUILDING:		C	
		00774	B. WING			6/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ST BENE	EDICTS SENIOR COM	IMUNITY	NESOTA BO OUD, MN 5	ULEVARD SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 16	21805			
21830	The director of nurs and revise policies dignity and provision education on provide director of nursing audit tool to ensure provided. TIME PERIOD FOR (21) days. MN St. Statute 144 Residents of HC Fassibility and provided in the provide	pation in planning treatment;	21830			2/24/20
	in the planning of the includes the opport alternatives with incopportunity to require care conferences, a family member or oboth. In the event of present, a family member or conferences. (b) If a resident of unconscious or correct communicate, the first sar required.	neir health care. This right unity to discuss treatment and dividual caregivers, the est and participate in formal and the right to include a other chosen representative or that the resident cannot be ember or other representative dent may be included in such who enters a facility is natose or is unable to facility shall make reasonable under paragraph (c) to notify				
		nber or a person designated in ent as the person to contact in				

Minnesota Department of Health

winnesc	ota Department of He	eaun				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
						,
		00774	B. WING		1	<i>,</i> 6/2020
		00774	<u> </u>		01/1	0/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
OT DENI	EDICTS SENIOR COM	IMUNUTY 1810 MIN	NESOTA BO	ULEVARD SOUTHEAST		
31 DENE	DIC 13 SENIOR COM	SAINT CL	OUD, MN 50	6304		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				DEI IOIENOT)		
21830	Continued From pa	nge 17	21830			
	•					
		the resident has been				
		lity. The facility shall allow the				
		participate in treatment				
		e facility knows or has reason				
		ent has an effective advance				
		trary or knows the resident has				
		that they do not want a family				
		n treatment planning. After				
		ember but prior to allowing a				
		participate in treatment				
		y must make reasonable				
		with reasonable medical				
	•	ine if the resident has				
		ce directive relative to the				
		re decisions. For purposes of				
		asonable efforts" include:				
	` '	e personal effects of the				
	resident;	a madical records of the				
		e medical records of the session of the facility;				
		ny emergency contact or				
		tacted under this section				
		nt has executed an advance				
		ner the resident has a				
		the resident normally goes for				
	care; and	the resident normally goes for				
		ne physician to whom the				
		oes for care, if known,				
		nt has executed an advance				
		ty notifies a family member or				
		ency contact or allows a family				
		ate in treatment planning in				
		is paragraph, the facility is not				
		r damages on the grounds that				
		ne family member or				
		or the participation of the				
		s improper or violated the				
	patient's privacy rig					
		asonable efforts to notify a				

Minnesota Department of Health STATE FORM

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00774	B. WING		C 01/16/2	2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE	-	
ST BENE	EDICTS SENIOR COM	MUNITY	NESOTA BO OUD, MN 5	ULEVARD SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE C	(X5) COMPLETE DATE
21830	the facility shall attermembers or a design examining the person and the medical recognishment of the facility a family memergency contact admission, the facility social service agency that the reson the facility has been member or designate county social service enforcement agency identifying and notified designated emergency service agency or lethat assists a facility subdivision is not like damages on the great the family member.	designated emergency contact, empt to identify family gnated emergency contact by conal effects of the resident cords of the resident in the acility. If the facility is unable ember or designated within 24 hours after the ity shall notify the county cy or local law enforcement ident has been admitted and in unable to notify a family sted emergency contact. The reagency and local law ery shall assist the facility in riving a family member or ency contact. A county social local law enforcement agency y in implementing this able to the resident for ounds that the notification of or emergency contact or the family member was improper	21830			
	by: Based on interview facility failed to ens reviewed for Advan Stay 2nd floor Sout care wishes identifi	h unit, had their current health ed clearly in the medical		Staff met with R228 on 1/14/2020 the resident's wishes in response noted discrepancy. The resident's electronic medical record and pap were updated to correspond approximately.	to the er chart	
	reviewed for Advance Directives on the Short Stay 2nd floor South unit, had their current health care wishes identified clearly in the medical record to ensure staff were aware of their wishes. Findings include: R228's admission record, dated 12/24/19, identified diagnoses including cellulitis (bacterial			A full facility audit was conducted 1/14/2020. R228 was the only resibe impacted by the electronic med record and paper chart not correspance appropriately. Staff received re-ed	dent to lical ponding	

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AND BLAN OF CORRECTION TO TREATMENT AND BLAN OF CORRECTION ALL MARCH.		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	A. BUILDING:					
	0077	74	B. WING		01/1	, 6/2020
NAME OF PROVIDER OR SUPP	.IER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST BENEDICTS SENIOR	COMMUNITY		NESOTA BO OUD, MN 5	OULEVARD SOUTHEAST 6304		
PREFIX (EACH DEFIC		DEFICIENCIES RECEDED BY FULL ING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21830 Continued Fro	n page 19		21830			
infection of the sepsis (blood is also identified Code" (person to get their heat R228's admiss dated 12/30/19 intact and requactivities of dated Tequactivities of dated Tequ	skin) of right unifection). The acceptance will allow all interest to started). on Minimum Ende tidentified R22 red extensive y living. B's electronic neode" listed on a lincluded a phromograph of the event of which was "DNR the event of which are placed from the done. The placed from the done. The placed from the done. The placed from the done was "DNR the event of which are placed from the done. The placed from the done of the done of the placed from the placed from the placed from the placed from the placed directive prefibe the appropriate which was the placed directive prefibe the appropriate which was a placed from the	nedical record the top of R228's hysician order, dated de." cal record included at Form, dated and and signed by h, which indicated (Do Not hitnessed cardiac or no cardiopulmonary l. In the event of dotracheal the mouth into the his does not include ase of choking." ogress notes, dated ed, "Pt. [patient] ignature." o, at 9:57 a.m. ed, if a resident was er chart included the erence of the oriate place to		on appropriately capturing, updati implementing residents' advance directive/code status wishes. Random chart audits will be compassure that resident's advance directive form assure that resident's advance directive form within the emedical record to the wishes indicated the Advance Directive form within paper chart. These audits will be conducted weekly for one month, monthly until the next "Quarterly Assurance" committee. The Director of Nursing and/or dewill report the findings of the audit quarterly "Quality Assurance" com A determination will be made if furinterventions are warranted as we determine the frequency for ongo audits.	pleted to rective electronic cated on the then esignee as at the inmittee.	

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Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00774	B. WING		I	C 16/2020	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
ST BENEDICTS SENIOR COMMU	NITY	NESOTA BOI OUD, MN 56	JLEVARD SOUTHEAST 304			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
the paper chart because reviewed with family and During an interview on RN-H stated she would record or to the electron however, "I would always to make sure." When interviewed on a stated, "Their [resident on PCC [Point Click Carecord utilized by the fainitial page on R228's of RN-F stated, "That's what their code status be. During an interview on RN-I stated, "I would go because that's where the documentation would be when interviewed on a stated she remembered thought it was in the howasn't sure. R228 indicated in the resuscitated, husband passed away watched as emergency resuscitate him. R228 signed saying that they my time." During a follow up interport in RN-F stated she is approximately seven in the process of the proximately seven in the proximately	1/14/20, at 9:58 a.m. ald always go by what's in se that is what's been and the doctor." 1/14/20, at 10:00 a.m. ald go to the paper medical price medical record, and so look at the signed form 1/14/20, at 10:04 a.m. RN-Fits] code status is right here, are] [electronic medical record. And the electronic medical record. And there I always check. I look fore I go into their room." 1/14/20, at 10:05 a.m. also look at the paper chart the most current be." 1/14/20, at 11:36 a.m. R228 and signing something, pospital, however, she cated her preference was because, when her	21830				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
					С	
		00774	B. WING		01/1	16/2020
NAME OF PRO	OVIDER OR SUPPLIER			STATE, ZIP CODE		
ST BENED	ICTS SENIOR COM	MUNITY	INNESOTA BO CLOUD, MN 5	OULEVARD SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
s n ptt h c to VF b ir p r tt ir b p E d w e tt w h a r F p " t t s F F (i e ir	dever been involved process is to call contense a job. I'm not such any a job. I'm not such arge of verifying the process is to call contense and interviewed of the patient of the patient's characteristic in the patient's characteristic in the [paper of the event that it's plue procedure. Happrocess." During an interviewed in the event that it's plue procedure. Happrocess." During an interviewed in the event of someone be their code status. Downs admitted, the discopital included in the reside the discopital included in the reside dis	nas no pulse] happens. I have d in one, but I know that the ode blue on the walkie, and a respond. All of those people sure, but I think someone is it the code status. We all work the resident has determined on 1/14/20, at 12:26 p.m. check to see if they are other staff, check code statut, the signed copy from the richart and electronic medicach, but the best place to verifg chart. That always happens a full resuscitation, start cod ppens on all shifts, that is the point of the paper chart in the peing unresponsive, to verify ON indicated when a resider lischarge orders from the e code status, and the rays verifies that with the Advance Directive Consent lent signed the form and it want's paper chart. DON stated staff and nursing work jointly get made in the record. They	n .". s I /, e e			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
,			A. BUILDING:				
		00774	B. WING			C 16/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ST BENE	EDICTS SENIOR COM	MIINITY	NESOTA BO OUD, MN 50	ULEVARD SOUTHEAST 6304			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
21830	Continued From pa	ge 22	21830				
	at 1:15 p.m. DON indicated staff are directed to verify the code status in the paper record, on the Advance Directive Consent Form, as this was the most current preference, signed by the resident and physician.						
	Review of the facility's policy, Advance Directives, revised 4/11, included, "Resident and/or family wishes regarding Advance Directives are obtained by Information and Registration during the admission processThe RN Evening Supervisor will check orders for agreement between resident wishes and physician's orderDiscussions with physician, resident, family members, and nursing staff need to be clearly documentedThe original copy of Advance Directives goes into the physician order packet of the chart for signing. A duplicate is filed in the "Advance Directive" section of the chart."						
	4/14, included, "Whrespiratory arrest thimmediately verified	nary Resuscitation, revised nen a resident has a cardiac or ne resident's code status is d," however, the policy does n as to what source should be					
	The Administrator, designee, could de policies and proced preferences for advand accurately ider or designee could ethe policies and pro Nursing or designe	THOD OF CORRECTION: Director of Nursing or velop, review, and/or revise lures to ensure resident vanced directives are honored utified. The Director of Nursing educate all appropriate staff on ocedures. The Director of e could develop monitoring ongoing compliance.					

Minnesota Department of Health

STATE FORM BR8Y11 If continuation sheet 23 of 24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		00774	B. WING			0
		00774	I .		01/1	16/2020
	PROVIDER OR SUPPLIER	1810 MIN		STATE, ZIP CODE DULEVARD SOUTHEAST		
ST BENE	EDICTS SENIOR COM	MIINIIV	OUD, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21830	Continued From pa	ge 23	21830			
21830		ge 23 R CORRECTION: Seven (7)	21830			

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