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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BR8Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00774

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

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

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

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/28/2020** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **174** (L18)
13.Total Certified Beds **174** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
2	172			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathleen Lucas, Unit Supervisor 03/25/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 03/25/2020 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/11/2020
(L33)

DETERMINATION APPROVAL

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
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING _____ B. WING _____	R 02/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments No deficiencies were issued at CMS Appendix Z Emergency Preparedness during the recertification survey exited on 1/16/20.	{E 000}		
{F 000}	INITIAL COMMENTS An off-site revisit was completed on 2/28/20, and the facility was found to have corrected all deficiencies issued as a result of the survey exited on 1/16/20. The facility is back in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents	{F 000}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00774	A. BUILDING: _____ B. WING _____	R 02/28/2020

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS:	{2 000}		
{21010}	MN Rule 4658.0610 Subp. 6 Dietary Staff Requirements-Eating. Subp. 6. Eating. All employees must consume food only in areas designated for employee	{21010}		

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{21010}	Continued From page 1 dining. An employee dining area must not be designated if consuming food in that location could cause contamination of other food, equipment, or utensils. This subpart does not apply to cooks or other persons designated by the cook who test the food for flavor and palatability. This MN Requirement is not met as evidenced by:	{21010}		
{21530}	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the	{21530}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{21530}	Continued From page 2 pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by:	{21530}		
{21805}	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by:	{21805}		
{21830}	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members.	{21830}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00774	A. BUILDING: _____ B. WING _____	R 02/28/2020

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{21830}	Continued From page 3 (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or	{21830}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{21830}	Continued From page 4	{21830}		

family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

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

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{21830}	Continued From page 5 the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by:	{21830}		

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

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4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/16/2020** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
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03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
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FISCAL YEAR ENDING DATE: (L35)
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And/Or Approved Waivers Of The Following Requirements:
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___ 4. 7-Day RN (Rural SNF)
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__ 7. Medical Director
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__ 9. Beds/Room

* Code: **B** (L12)

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2	172			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Kathleen Lucas, Unit Supervisor — 03/09/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 03/10/2020 (L20)

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

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

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21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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09/15/1986
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(L44)
B. Rescind Suspension Date:
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26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
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INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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.

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.

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

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
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING _____ B. WING _____	C 01/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 1/13/20 to 1/16/20, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 1/13/20 to 1/16/20 a standard survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found not to be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5350091C. No deficiencies issued. H5350092C. No deficiencies issued. H5350093C. No deficiencies issued. H5350094C. No deficiencies issued. The following complaint was found unsubstantiated: H5350090C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/07/2020

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F 000	Continued From page 1 validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		2/24/20

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F 550	Continued From page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely care of a resident was provided for 1 of 2 residents (R112) who waited for 33 minutes for the call light to be answered. In addition, the facility failed to ensure a catheter bag containing urine was concealed from public view for 1 of 3 residents (R73) residing on the unit with a catheter. Findings include: R112's admission Minimum Data Set (MDS) dated 12/29/19, identified R112 had moderate cognitive impairment and required extensive assistance with activities of daily living (ADLs) R112's fall Care Area Assessment (CAA) dated 12/26/19, identified R112 was unsteady when goes to stand, walk, turn, move on and off toilet, and when transferred, needed staff assist to stabilize. Had a history of falling, with a fall in facility when attempted to self-transfer. R112's care plan revised 12/15/19, identified R112 had a self care deficit related to weakness, care planned interventions included assistance of one staff to transfer with wheeled walker and assistance of one staff with toileting needs. Care plan also indicated R112 had a potential for injury related to history of falls, did not consistently use	F 550	R112□s care plan was updated on 1/14/2020 indicating for staff to stay with resident while on the toilet. R73□s urinary catheter bag was covered with a privacy bag on 1/16/2020. Staff will receive education on the importance of maintaining resident□s dignity, including responding to resident needs within a timely manner. Staff will also receive education on covering urinary catheter drainage bags. A standard task has been created within our electronic medical record which can be readily assigned as a reminder for staff to cover urinary drainage bags with a privacy bag, for those residents whom use a urinary catheter. Random observational audits will be completed to assure that residents whom use a urinary catheter drainage bag, have that bag within a privacy bag. These audits will be conducted weekly for one month, then monthly until the next Quarterly Assurance committee. The Director of Nursing and/or designee will report the findings of the audits at the quarterly Quality Assurance committee. A	

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F 550	Continued From page 3 call light, had poor safety awareness, and self-transferred. Care planed interventions included call light kept within reach in bedroom, encourage R112 to utilize call light, R112 had pendant call light, risks and consequences of self-transfers was discussed which included falls, fractures and injuries up to and including death. During interview on 01/13/20, at 1:08 p.m. family member (FM)-A stated R112 had been left on the toilet for an extended period of time, R112 had utilized both the bathroom pull cord in addition to pendant worn on a chain around the neck. FM-A stated the family had received phone call from facility on 1/12/20, caller had apologized, stated they (the facility were in the wrong) then stated R112 had the call light on for over 30 minutes, had transferred self from the toilet to the wheelchair, there were no injuries. FM-A further stated R112 required assistance to transfer, was concerned there could have been a fall with a potential for injury. R112 was seated next to FM-A, was crying and repeatedly stated "they left me alone and didn't come back, I had the lights on for an hour". A progress note dated 1/12/2020, identified updated family regarding toileting situation in the 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.	F 550	determination will be made if further interventions are warranted as well as to determine the frequency for ongoing audits.	

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F 550	Continued From page 4	F 550		

When interviewed on 1/16/20, at 9:18 a.m. RN-B stated R112 was left on the toilet alone, according to call light report the bathroom call light and pendant call light had been on for 33 minutes, facility was not sure at what point R112 had independently transferred to the wheelchair. RN-B further stated this was poor customer service, call lights should have been answered by staff within ten minutes.

Reviewed facility Device Activity Report with RN-B for R112 printed 1/16/20, identified R112 had used the pendant call light on 1/12/20, at 9:40 a.m. with pendant being cleared by staff at 10:14 a.m., call light had been on for 34 minutes 14 seconds. RN-B stated that was when R112 utilized the pendant to be placed on the toilet. On 1/12/20, at 10:27 a.m. R112 utilized pendant call 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.

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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 containing urine hanging uncovered below Broda chair visible from hallway.

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

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F 550	Continued From page 6 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. During phone interview on 1/16/20, at 9:14 a.m. FM-A stated R73 was a very dignified person before dementia progressed, R73 would be upset and embarrassed to know other people could see the urine in the catheter bag. When interviewed on 1/16/20, at 9:29 a.m. RN-B stated privacy bags were to be in place for all residents with catheter drainage bags for their dignity. A facility Dignity Policy - Long Term Care/Swing Bed revised 6/2019, identified all staff were to assist the resident to maintain and enhance self-worth and dignity.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578		2/24/20

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F 578	Continued From page 7 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 6 residents (R228) 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 infection of the skin) of right upper limb, and	F 578	Staff met with R228 on 1/14/2020 to verify the resident's wishes in response to the noted discrepancy. The resident's electronic medical record and paper chart were updated to correspond appropriately. A full facility audit was conducted on 1/14/2020. R228 was the only resident to be impacted by the electronic medical record and paper chart not corresponding appropriately. Staff received re-education on appropriately capturing, updating and	

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F 578	Continued From page 8 sepsis (blood infection). The admission record also identified R228's advance directive as "Full Code" (person will allow all interventions needed to get their heart started). R228's admission Minimum Data Set (MDS), dated 12/30/19, identified R228 was cognitively intact and required extensive assistance for activities of daily living. Review of R228's electronic medical record included "Full Code" listed on the top of R228's initial page, and included a physician order, dated 12/24/19, identifying "Full Code." Review of R228's paper medical record included an Advance Directive Consent Form, dated and signed by R228 on 12/24/19, and signed by R228's physician on 12/26/19, which indicated R228's preference was "DNR (Do Not Resuscitate) In the event of witnessed cardiac or witnessed respiratory arrest, no cardiopulmonary resuscitation shall be initiated. In the event of sudden respiratory failure, endotracheal intubation (tubes placed from the mouth into the lungs) should not be done. This does not include emergency management in case of choking." During a review of R228's progress notes, dated 12/24/19, at 8:59 p.m. included, "Pt. [patient] signed DNR, waiting on MD signature." During an interview on 1/14/20, at 9:57 a.m. registered nurse (RN)-D stated, if a resident was found unresponsive, the paper chart included the official advance directive preference of the resident, would be the appropriate place to confirm the resident's code status.	F 578	implementing residents' advance directive/code status wishes. Random chart audits will be completed to assure that resident's advance directive wishes are consistent within the electronic medical record to the wishes indicated on the Advance Directive form within the paper chart. These audits will be conducted weekly for one month, then monthly until the next "Quarterly Assurance" committee. The Director of Nursing 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 to determine the frequency for ongoing audits.	

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During an interview on 1/14/20, at 9:58 a.m. RN-E stated, "We would always go by what's in the paper chart because that is what's been reviewed with family and the doctor."

During an interview on 1/14/20, at 10:00 a.m. RN-H stated she would go to the paper medical record or to the electronic medical record, however, "I would always look at the signed form to make sure."

When interviewed on 1/14/20, at 10:04 a.m. RN-F stated, "Their [residents] code status is right here, on PCC [Point Click Care] [electronic medical record utilized by the facility]," pointing to the initial page on R228's electronic medical record. RN-F stated, "That's where I always check. I look at their code status before I go into their room."

During an interview on 1/14/20, at 10:05 a.m. RN-I stated, "I would go look at the paper chart because that's where the most current documentation would be."

When interviewed on 1/14/20, at 11:36 a.m. R228 stated she remembered signing something, thought it was in the hospital, however, she wasn't sure. R228 indicated her preference was to not be resuscitated, because, when her husband passed away five months ago, she watched as emergency personnel attempted to resuscitate him. R228 stated, "I don't want that. I signed saying that they should just let me go. It's my time."

During a follow up interview on 1/14/20, at 12:20 p.m. RN-F stated she had worked at the facility approximately seven months, and stated, "You are never alone when a code blue [universally

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recognized emergency code when someone stops breathing or has no pulse] happens. I have never been involved in one, but I know that the process is to call code blue on the walkie, and then several people respond. All of those people have a job. I'm not sure, but I think someone is in charge of verifying the code status. We all work together to do what the resident has determined."

When interviewed on 1/14/20, at 12:26 p.m. RN-G stated, "We check to see if they are breathing, alert the other staff, check code status in the patient's chart, the signed copy from the patient. They [paper chart and electronic medical record] should match, but the best place to verify that is in the [paper] chart. That always happens, in the event that it's a full resuscitation, start code blue procedure. Happens on all shifts, that is the process."

During an interview on 1/14/20, at 12:45 p.m. the director of nursing (DON) stated the process would include checking the paper chart in the event of someone being unresponsive, to verify their code status. DON indicated when a resident was admitted, the discharge orders from the hospital included the code status, and the admitting nurse always verifies that with the resident, using the Advance Directive Consent Form, and the resident signed the form and it was placed in the resident's paper chart. DON stated, "Health information staff and nursing work jointly to ensure changes get made in the record. They should always match."

Review of the facility's undated Code Blue Record, located on the facility's emergency cart (a wheeled container carrying medicine and equipment for use in emergency resuscitations),

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ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 11 included, "CODE STATUS VERIFIED BY:" with a line for a signature. When interviewed on 1/14/20, 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 process...The RN Evening Supervisor will check orders for agreement between resident wishes and physician's order...Discussions with physician, resident, family members, and nursing staff need to be clearly documented...The 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." Review of the facility's policy, Code Blue-Cardiopulmonary Resuscitation, revised 4/14, included, "When a resident has a cardiac or respiratory arrest the resident's code status is immediately verified," however, the policy does not include direction as to what source should be used to verify the code status.	F 578		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law	F 755		2/24/20

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F 755	Continued From page 12 permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This 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:	F 755	R48's Maalox order was clarified on 1/15/2020, leaving only one available "as needed order". As noted within the statement of deficiency, the expired vial of tuberculin was immediately disposed on 1/15/2020. Nursing staff will receive education on the need to review provider orders for the need for clarifications such as parameters for use and/or elimination of potentially duplicative orders.	

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F 755	Continued From page 13 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 200-200-20 mg/5 ml. Give 10 cc by mouth every 2 hours as needed for indigestion, nausea. 2) Maalox regular strength suspension 200-200-20 mg/5 ml. Give 20 cc by mouth every 2 hours as needed for indigestion, nausea. The orders did not direct when to give 10 cc versus 20 cc's or visa versa. Review of R48's Medication Administration Records (MAR) since the Maalox order date of 7/15/19, identified R48 received Maalox PRN 2 times. R48's July 2019 MAR identified R48 received 20 cc of Maalox on 7/15/19 at 10:11 a.m. R48's August 2019 MAR indicated R48 received 20 cc of Maalox on August 24th at 9:34 a.m. R48's record lacked the reason R48 received 20 cc dose versus the 10 cc dose. During an interview on 1/15/20, at 1:06 p.m. licensed practical nurse (LPN)-D was asked how she would administer Maalox to R48. LPN-D reviewed R48's January 2020 MAR and stated if R48 had indigestion or nausea, R48 would receive 20 cc of Maalox. When directed to R48's second order for Maalox 10 cc, LPN-D stated "Oh [R48] does" have an order for 10 cc as well.	F 755	A process was identified to review stock medications for expiration/beyond use dates. This process will be completed monthly. Random chart audits will be completed throughout the units within facility to ensure that orders are being clarified for parameters for use and/or elimination of potentially duplicative orders. Random observational audits will be completed to check for medications which are expired/beyond use. The Director of Nursing and/or designee will report the findings of the audits at the quarterly “Quality Assurance” committee and determine if further interventions are warranted as well as to determine the frequency for ongoing audits.	

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F 755	Continued From page 14	F 755		

LPN-D then stated she would give the 10 cc first, then after 2 hours, if indigestion or nausea was not better would then probably administer 20 cc. LPN-D stated orders generally have perimeters when there are different dosages ordered, but R48's order did not have perimeters for the Maalox ordered.

During an interview on 1/15/20, at 12:06 p.m. the consulting pharmacist (CP)-A stated he try's to catch dosage discrepancies during is monthly reviews. CP-A stated R48's Maalox order was missed. CP-A stated he would recommend the physician to clarify the Maalox order for either 10 cc or 20 cc PRN.

The facility's policy Physician Orders, dated 10/11, directed physician orders are obtained by the staff RN or LPN and transcribed by the RN, LPN, or health information specialist in accordance with procedures outlined. The nurse will call/fax the pharmacy to dictate the order. The pharmacist writes a facsimile prescription, files and fills the prescription. The procedure indicated the night nurse (or second nurse during the shift order was received) will double check/verify that all new orders are complete and accurate then initial and date the right side of the "red line".

During facility task for medication storage and labeling on 1/15/2020 at 10:42 a.m. on the Parkers Way neighborhood with licensed practical nurse (LPN)-A stated an opened vial of a tuberculin medication used for tuberculosis skin test(TST) was opened on 10/23/2019 with an expiration date of 11/22/2019. This information was hand written on the vial and was found in the med room refrigerator. LPN-A stated Parkers

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F 755	Continued From page 15	F 755		

Way rarely admitted residents from the hospital, the residents would typically be admitted from one of the two short stay units. The TST test determines if someone has developed an immune response to the bacterium that causes TB (tuberculosis a potentially serious bacterial disease that mainly affects the lungs. Tuberculosis is a disease caused by the bacteria that are spread through the air from person to person. If not treated properly, the TB disease can be fatal). LPN-A stated the medication was available for staff to administer to residents. LPN-A immediately disposed of the expired medication in a medication destruction container. The expired vial of the TB skin test was in circulation for nearly 2 months.

During interview on 1/16/2020, at 8:17 a.m. nurse manager (NM)-A indicated there was no formal process to review stock medications for expiration date. Further NM-A stated this should be done on the night shift. NM-A was unable to provide the frequency of when the med refrigerator was checked for expired medications. NM-A additionally stated the expiration date on the medication should be reviewed prior to administration. NM-A stated the nursing staff should write open date and expiration date on opened medications. The expiration date would depend on the type of medication, generally 28 days.

During interview on 1/16/2020, at 8:48 a.m. with registered nurse (RN)-C three Tuberculin vials were located in the refrigerator in the medication room. RN-C stated two vials were not opened and the staff would go by the expiration date from the manufacturers., one vial was opened with the date opened and the expiration date which was

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F 755	Continued From page 16 30 days after opening and was not expired and hand written on the tag. RN-C stated that is the facilities current process. Review of policy titled " Medication Guidelines-Long Term Care" dated 4/2018 with a review date of 12/2019 indicated medications are administered by qualified personnel who perform monitoring of the resident's response to medication administered. Medications are to be administered in a timely manner, accurately and in a way to allow for maximum benefit. Personnel administering medications practice safe medication administration, including the correct process for resident identification. Further the policy indicated no discontinued, outdated or deteriorated medications are available for use in this facility. Additionally, check expiration date/beyond use date on package/container. The policy indicated stock medication should be labeled with the following: Original manufacturer or pharmacy applied label the includes: Medication name Strength Quantity Accessory instructions Lot name and expiration date if applicable. The policy lacked documentation on the facility process to check for outdated medications.	F 755		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		2/24/20

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F 812	Continued From page 17 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide proper hand hygiene during meal service, on the Short Stay 2nd floor South unit, for 1 of 1 resident (R278), during observation of room tray preparation. Findings include: R278's admission record, dated 1/10/20, identified diagnoses of cirrhosis of liver (scar 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	F 812	All Nutrition staff, including NSA-A, will use proper hand hygiene and glove usage when serving resident meals. All Nutrition staff will review and sign off on hand hygiene/glove usage. Observational Audits will be implemented weekly for one month to ensure all Nutrition staff are properly following the hand hygiene/glove usage policy. The Dietary Supervisor 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 to determine the frequency for ongoing audits.	

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F 812	Continued From page 18	F 812		

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 with the same gloved hand, and grabbed a handful of shredded cheese. NSA-A sprinkled the shredded cheese on top of the lettuce and tomato, and dropped several shreds of the cheese onto the floor and the countertop. Using the same gloved hand, NSA-A picked up the shred of cheese from the countertop and put it in her mouth. NSA-A replaced the lid on the container, closed the refrigerator door, and placed the bowl onto R278's tray. Without removing gloves, NSA-A walked to the steam table and with the same gloved hand, picked up two chicken drumsticks and placed them on a

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F 812	Continued From page 19	F 812		

plate. NSA-A used a utensil to add macaroni and cheese and beans to the plate, and brought the plate to the awaiting tray. NSA-A removed the gloves, and washed her hands. Registered Nurse (RN)-J picked up the tray and walked to R278's room. Upon delivery, RN-J used a thermometer to temp the food, as requested, and because the macaroni and cheese was 122 degrees, and R278 requested the food be warmer, the tray was removed from the room and replaced with a new tray.

When interviewed on 1/13/20, at 12:43 p.m. NSA-A stated she didn't realize that she had picked up the shredded cheese on the countertop and put it in her mouth, and then used the same gloved hand to pick up two chicken drumsticks. NSA-A stated, "I shouldn't have done that," and indicated she thought she had used a fork to put the chicken on the plate because she shouldn't be touching food when serving, even with gloved hands. NSA-A stated, "I didn't realize I used my fingers to dish up the food."

During an interview on 1/16/20, at 10:44 a.m. the supervisor of nutritional services (SNS) stated nutritional services staff should always use a utensil to serve food as that is standard practice. SNS stated, "They should never be doing that [serving food with hands]." SNS stated, "Nothing goes in their mouth," while serving food, and indicated the staff should have immediately removed the gloves, washed hands, and started over. SNS stated nutritional services staff are trained over and over about glove use and handwashing, and provided documentation of the education staff receive.

Review of the facility's undated Nutrition Services

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F 812	Continued From page 20 Training/Education Guide, included, "Improper handling of food and poor personal hygiene of food handlers are leading causes of food borne illness out breaks." Also included, "Food service workers are required to thoroughly wash hands using soap and water when ever hands or gloves are contaminated including...After touching any bare part of the body or hair." The Guide further indicated, "You may not eat or drink in the kitchen or dining rooms..."	F 812		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 640	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (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 transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure Minimum Data Set (MDS) assessments were submitted timely for 1 of 2 residents (R2) reviewed for Resident Assessments. Findings include: 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.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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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ST BENEDICTS SENIOR COMMUNITY	**1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department Of Public Safety, State Fire Marshal Division. At the time of this survey, St. Benedicts Senior Community was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/07/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/14/2020**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 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 one building. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and areas open to the	K 000		

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	245350	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/14/2020**

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K 000	Continued From page 2 corridors that is monitored for automatic fire department notification. The facility has a capacity of 174 beds and had a census of 141 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to test and maintain the Fire Alarm System in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. The deficient practice could affect 141 out of 141 residents and an undetermined amount of staff and visitors. 9.7.5, 9.7.7, 9.7.8. Findings include: During documentation review between 8:30 AM and 3:30 PM on 01/14/2020, documentation reviewed revealed: 1. Discrepancies in the amount of the Smoke	K 345	A fire system test has been scheduled to assure the discrepancies in the fire alarm report matches the inventoried system components. Any changes to the system in the form of additions or deletions will be verified and these documents will be maintained in the Fire Safety book to provide verification to the Fire Marshall. The maintenance director and/or designee will report the findings at the quarterly "Quality Assurance" committee.	2/17/20

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K 345	Continued From page 3 Detectors, Pull Stations and Heat detectors from the Fire alarm report 2018 to the current 2019. 2. The most current Fire Alarm report was dated 10/22/2019 and the previous fire alarm report was dated 9/19/2018. This would be outside of NFPA 72 standard. This deficient condition was confirmed by the Director of Maintenance.	K 345		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to install the sprinkler system in accordance with the 2012 edition of the Life Safety Code (NFPA 101) sections 19.3.5.1, 9.7.1.1 and the 2010 edition of NFPA 13,	K 351	The light fixtures will be replaced with fixtures that will not obstruct the sprinklers. The fire suppression vendor will audit for	2/17/20

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K 351	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.	K 351	potential obstruction of sprinklers during annual visit. Audits will be conducted on a random basis to assure compliance. Education will be conducted for Maintenance staff to increase awareness of potential scenarios of obstructions to the sprinklers. 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 to determine the frequency for ongoing audits.	
K 355 SS=D	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: On the facility tour between 8:30 AM and 3:30 PM	K 355	The chair which was obstructing the fire extinguisher was removed from the area. The monthly preventative maintenance checklist will be updated to include accessibility of fire extinguishers. Education will be conducted for maintenance staff regarding accessibility guidelines for fire extinguishers. Audits will be conducted on a random basis to assure compliance.	2/17/20

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K 355	Continued From page 5 on 01/14/2020, observations revealed the fire extinguisher was obstructed by a chair in memory lane. This deficient condition was confirmed by the Director of Maintenance.	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 to determine the frequency for ongoing audits.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview the facility failed to conduct inspections of all fire rated doors and required by NFPA 101 (12) Life Safety Code, section 7.2.1.15.2 & 7.2.1.15.4. This deficient practice could allow for the spread of fire if the doors were not maintained in accordance with its rating. This could affect all 141 residents and an undetermined amount of staff and visitors.	K 761	An audit of the fire rated doors was conducted on January 29, 2020 to assess condition of doors. Based on this assessment, it was determined that four doors will be replaced and five doors be repaired. Repairs to doors will be conducted and replacement doors will arrive the week of March 23rd. An assessment of the fire rated doors will	3/23/20

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K 761	Continued From page 6 Findings include: During documentation review between8:30 AM and 3:30 PM on 01/14/2020, documentation review revealed there were no repairs made to the doors from the annual inspections dated 07/01/2019 of the fire rated doors. This deficient condition was confirmed by the Facility Maintenance Director.	K 761	be performed annually by trained staff and repair/replacement will be determined and acted upon. Education will be performed by trained facilities staff to include entire maintenance department as it relates to evaluation of doors and repairs. The maintenance director and/or designee will report the findings at the quarterly "Quality Assurance" committee.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. The deficient practice could affect all residents, staff and an undetermined amout of visitors. Findings include:	K 901	A risk assessment audit has been completed and entered into the work order system. Going forward the risk assessment audit will be completed as required by NFPA. The maintenance director and/or designee will report the findings at the quarterly "Quality Assurance" committee.	2/17/20

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K 901	Continued From page 7 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.	K 901		

DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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

"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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00774	A. BUILDING: _____ B. WING _____	C 01/16/2020

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/13/20 to 1/16/20, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Complaints were also investigated. The following complaints were found to be substantiated:	2 000		

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2 000	Continued From page 1 H5350091C. No licensing orders issued. H5350092C. No licensing orders issued. H5350093C. No licensing orders issued. H5350094C. No licensing orders issued. The following complaint was found unsubstantiated: H5350090C Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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	2 000		

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2 000	Continued From page 2 Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21010	MN Rule 4658.0610 Subp. 6 Dietary Staff Requirements-Eating. Subp. 6. Eating. All employees must consume food only in areas designated for employee dining. An employee dining area must not be designated if consuming food in that location could cause contamination of other food, equipment, or utensils. This subpart does not apply to cooks or other persons designated by the cook who test the food for flavor and palatability. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to provide proper hand hygiene during meal service, on the Short Stay 2nd floor South unit, for 1 of 1 resident (R278), during observation of room tray preparation. Findings include: R278's admission record, dated 1/10/20, identified diagnoses of cirrhosis of liver (scar	21010	All Nutrition staff, including NSA-A, will use proper hand hygiene and glove usage when serving resident meals. All Nutrition staff will review and sign off on hand hygiene/glove usage. Observational Audits will be implemented weekly for one month to ensure all Nutrition staff are properly following the hand hygiene/glove usage policy.	2/24/20

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ST BENEDICTS SENIOR COMMUNITY	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

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21010	Continued From page 3 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 with the same gloved hand, and	21010	The Dietary Supervisor 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 to determine the frequency for ongoing audits.	

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grabbed a handful of shredded cheese. NSA-A sprinkled the shredded cheese on top of the lettuce and tomato, and dropped several shreds of the cheese onto the floor and the countertop. Using the same gloved hand, NSA-A picked up the shred of cheese from the countertop and put it in her mouth. NSA-A replaced the lid on the container, closed the refrigerator door, and placed the bowl onto R278's tray. Without removing gloves, NSA-A walked to the steam table and with the same gloved hand, picked up two chicken drumsticks and placed them on a plate. NSA-A used a utensil to add macaroni and cheese and beans to the plate, and brought the plate to the awaiting tray. NSA-A removed the gloves, and washed her hands. Registered Nurse (RN)-J picked up the tray and walked to R278's room. Upon delivery, RN-J used a thermometer to temp the food, as requested, and because the macaroni and cheese was 122 degrees, and R278 requested the food be warmer, the tray was removed from the room and replaced with a new tray.

When interviewed on 1/13/20, at 12:43 p.m. NSA-A stated she didn't realize that she had picked up the shredded cheese on the countertop and put it in her mouth, and then used the same gloved hand to pick up two chicken drumsticks. NSA-A stated, "I shouldn't have done that," and indicated she thought she had used a fork to put the chicken on the plate because she shouldn't be touching food when serving, even with gloved hands. NSA-A stated, "I didn't realize I used my fingers to dish up the food."

During an interview on 1/16/20, at 10:44 a.m. the supervisor of nutritional services (SNS) stated nutritional services staff should always use a utensil to serve food as that is standard practice.

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21010	Continued From page 5 SNS stated, "They should never be doing that [serving food with hands]." SNS stated, "Nothing goes in their mouth," while serving food, and indicated the staff should have immediately removed the gloves, washed hands, and started over. SNS stated nutritional services staff are trained over and over about glove use and handwashing, and provided documentation of the education staff receive. Review of the facility's undated Nutrition Services Training/Education Guide, included, "Improper handling of food and poor personal hygiene of food handlers are leading causes of food borne illness out breaks." Also included, "Food service workers are required to thoroughly wash hands using soap and water when ever hands or gloves are contaminated including...After touching any bare part of the body or hair." The Guide further indicated, "You may not eat or drink in the kitchen or dining rooms..." SUGGESTED METHOD OF CORRECTION: The Supervisor of Nutritional Services (SNS) could review and revise policies and procedures to ensure proper hand hygiene during meal service in the facility. The SNS could educate all appropriate staff. The SNS could develop monitoring systems to ensure ongoing compliance and report those results to the quality improvement committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one days	21010		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be	21530		2/24/20

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reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change.

B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician.

C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.

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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. 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 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 200-200-20 mg/5 ml. Give 10 cc by mouth every 2 hours as needed for indigestion, nausea. 2) Maalox regular strength suspension 200-200-20 mg/5 ml. Give 20 cc by mouth every 2 hours as needed for indigestion, nausea. The orders did not direct when to give 10 cc versus 20 cc's or visa versa. Review of R48's Medication Administration Records (MAR) since the Maalox order date of 7/15/19, identified R48 received Maalox PRN 2 times. R48's July 2019 MAR identified R48 received 20 cc of Maalox on 7/15/19 at 10:11	21530	R48's Maalox order was clarified on 1/15/2020, leaving only one available as needed order. As noted within the statement of deficiency, the expired vial of tuberculin was immediately disposed on 1/15/2020. Nursing staff will receive education on the need to review provider orders for the need for clarifications such as parameters for use and/or elimination of potentially duplicative orders. A process was identified to review stock medications for expiration/beyond use dates. This process will be completed monthly. Random chart audits will be completed throughout the units within facility to ensure that orders are being clarified for parameters for use and/or elimination of potentially duplicative orders. Random observational audits will be completed to check for medications which are expired/beyond use. The Director of Nursing and/or designee will report the findings of the audits at the quarterly “Quality Assurance” committee and determine if further interventions are warranted as well as to determine the frequency for ongoing audits.	

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a.m. R48's August 2019 MAR indicated R48 received 20 cc of Maalox on August 24th at 9:34 a.m. R48's record lacked the reason R48 received 20 cc dose versus the 10 cc dose.

During an interview on 1/15/20, at 1:06 p.m. licensed practical nurse (LPN)-D was asked how she would administer Maalox to R48. LPN-D reviewed R48's January 2020 MAR and stated if R48 had indigestion or nausea, R48 would receive 20 cc of Maalox. When directed to R48's second order for Maalox 10 cc, LPN-D stated "Oh [R48] does" have an order for 10 cc as well. LPN-D then stated she would give the 10 cc first, then after 2 hours, if indigestion or nausea was not better would then probably administer 20 cc. LPN-D stated orders generally have perimeters when there are different dosages ordered, but R48's order did not have perimeters for the Maalox ordered.

During an interview on 1/15/20, at 12:06 p.m. the consulting pharmacist (CP)-A stated he try's to catch dosage discrepancies during is monthly reviews. CP-A stated R48's Maalox order was missed. CP-A stated he would recommend the physician to clarify the Maalox order for either 10 cc or 20 cc PRN.

The facility's policy Physician Orders, dated 10/11, directed physician orders are obtained by the staff RN or LPN and transcribed by the RN, LPN, or health information specialist in accordance with procedures outlined. The nurse will call/fax the pharmacy to dictate the order. The pharmacist writes a facsimile prescription, files and fills the prescription. The procedure indicated the night nurse (or second nurse during the shift order was received) will double check/verify that all new orders are complete and accurate then

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21530	Continued From page 9 initial and date the right side of the "red line". During facility task for medication storage and labeling on 1/15/2020 at 10:42 a.m. on the Parkers Way neighborhood with licensed practical nurse (LPN)-A stated an opened vial of a tuberculin medication used for tuberculosis skin test(TST) was opened on 10/23/2019 with an expiration date of 11/22/2019. This information was hand written on the vial and was found in the med room refrigerator. LPN-A stated Parkers Way rarely admitted residents from the hospital, the residents would typically be admitted from one of the two short stay units. The TST test determines if someone has developed an immune response to the bacterium that causes TB (tuberculosis a potentially serious bacterial disease that mainly affects the lungs. Tuberculosis is a disease caused by the bacteria that are spread through the air from person to person. If not treated properly, the TB disease can be fatal). LPN-A stated the medication was available for staff to administer to residents. LPN-A immediately disposed of the expired medication in a medication destruction container. The expired vial of the TB skin test was in circulation for nearly 2 months. During interview on 1/16/2020, at 8:17 a.m. nurse manager (NM)-A indicated there was no formal process to review stock medications for expiration date. Further NM-A stated this should be done on the night shift. NM-A was unable to provide the frequency of when the med refrigerator was checked for expired medications. NM-A additionally stated the expiration date on the medication should be reviewed prior to administration. NM-A stated the nursing staff should write open date and expiration date on opened medications. The expiration date would	21530		

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21530	Continued From page 10 depend on the type of medication, generally 28 days. During interview on 1/16/2020, at 8:48 a.m. with registered nurse (RN)-C three Tuberculin vials were located in the refrigerator in the medication room. RN-C stated two vials were not opened and the staff would go by the expiration date from the manufacturers., one vial was opened with the date opened and the expiration date which was 30 days after opening and was not expired and hand written on the tag. RN-C stated that is the facilities current process. Review of policy titled " Medication Guidelines-Long Term Care" dated 4/2018 with a review date of 12/2019 indicated medications are administered by qualified personnel who perform monitoring of the resident's response to medication administered. Medications are to be administered in a timely manner, accurately and in a way to allow for maximum benefit. Personnel administering medications practice safe medication administration, including the correct process for resident identification. Further the policy indicated no discontinued, outdated or deteriorated medications are available for use in this facility. Additionally, check expiration date/beyond use date on package/container. The policy indicated stock medication should be labeled with the following: Original manufacturer or pharmacy applied label the includes: Medication name Strength Quantity Accessory instructions Lot name and expiration date if applicable. The policy lacked documentation on the facility process to check for outdated medications.	21530		

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21530	Continued From page 11 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy reviews and irregularities including policies related to medication monitoring systems to check for expiration. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure pharmacy reviews are timely, irregularities are being acted upon and expired medications are being properly disposed of. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21530		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely care of a resident was provided for 1 of 2 residents (R112) who waited for 33 minutes for the call light to be answered. In addition, the facility failed to ensure a catheter bag containing urine was concealed from public view for 1 of 3 residents (R73) residing on the unit with a catheter.	21805	R112's care plan was updated on 1/14/2020 indicating for staff to stay with resident while on the toilet. R73's urinary catheter bag was covered with a privacy bag on 1/16/2020. Staff will receive education on the importance of maintaining resident's	2/24/20

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21805	Continued From page 12 Findings include: R112's admission Minimum Data Set (MDS) dated 12/29/19, identified R112 had moderate cognitive impairment and required extensive assistance with activities of daily living (ADLs) R112's fall Care Area Assessment (CAA) dated 12/26/19, identified R112 was unsteady when goes to stand, walk, turn, move on and off toilet, and when transferred, needed staff assist to stabilize. Had a history of falling, with a fall in facility when attempted to self-transfer. R112's care plan revised 12/15/19, identified R112 had a self care deficit related to weakness, care planned interventions included assistance of one staff to transfer with wheeled walker and assistance of one staff with toileting needs. Care plan also indicated R112 had a potential for injury related to history of falls, did not consistently use call light, had poor safety awareness, and self-transferred. Care planed interventions included call light kept within reach in bedroom, encourage R112 to utilize call light, R112 had pendant call light, risks and consequences of self-transfers was discussed which included falls, fractures and injuries up to and including death. During interview on 01/13/20, at 1:08 p.m. family member (FM)-A stated R112 had been left on the toilet for an extended period of time, R112 had utilized both the bathroom pull cord in addition to pendant worn on a chain around the neck. FM-A stated the family had received phone call from facility on 1/12/20, caller had apologized, stated they (the facility were in the wrong) then stated R112 had the call light on for over 30 minutes, had transferred self from the toilet to the	21805	dignity, including responding to resident needs within a timely manner. Staff will also receive education on covering urinary catheter drainage bags when in public areas. A standard task has been created within our electronic medical record which can be readily assigned as a reminder for staff to cover urinary drainage bags with a privacy bag, for those residents whom use a urinary catheter. Random observational audits will be completed to assure that residents whom use a urinary catheter drainage bag, have that bag within a privacy bag. These audits will be conducted weekly for one month, then monthly until the next “Quarterly Assurance” committee. The Director of Nursing 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 to determine the frequency for ongoing audits.	

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wheelchair, there were no injuries. FM-A further stated R112 required assistance to transfer, was concerned there could have been a fall with a potential for injury. R112 was seated next to FM-A, was crying and repeatedly stated "they left me alone and didn't come back, I had the lights on for an hour".

A progress note dated 1/12/2020, identified updated family regarding toileting situation in the 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.

When interviewed on 1/16/20, at 9:18 a.m. RN-B stated R112 was left on the toilet alone, according to call light report the bathroom call light and pendant call light had been on for 33 minutes, facility was not sure at what point R112 had independently transferred to the wheelchair. RN-B further stated this was poor customer service, call lights should have been answered by staff within ten minutes.

Reviewed facility Device Activity Report with RN-B for R112 printed 1/16/20, identified R112 had used the pendant call light on 1/12/20, at 9:40 a.m. with pendant being cleared by staff at 10:14 a.m., call light had been on for 34 minutes 14 seconds. RN-B stated that was when R112 utilized the pendant to be placed on the toilet. On 1/12/20, at 10:27 a.m. R112 utilized pendant call

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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 containing urine hanging uncovered below Broda

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21805	Continued From page 15 chair visible from hallway. 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. During phone interview on 1/16/20, at 9:14 a.m. FM-A stated R73 was a very dignified person before dementia progressed, R73 would be upset and embarrassed to know other people could see the urine in the catheter bag. When interviewed on 1/16/20, at 9:29 a.m. RN-B stated privacy bags were to be in place for all residents with catheter drainage bags for their dignity. A facility Dignity Policy - Long Term Care/Swing Bed revised 6/2019, identified all staff were to assist the resident to maintain and enhance self-worth and dignity.	21805		

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21805	Continued From page 16 SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review and revise policies and procedures related to dignity and provision of care, and provide staff education on providing dignified care. The director of nursing or designee could develop an audit tool to ensure dignified resident care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in	21830		2/24/20

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

(1) examining the personal effects of the resident;

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

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

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

(c) In making reasonable efforts to notify a

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21830	Continued From page 18 family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 6 residents (R228) 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	21830	Staff met with R228 on 1/14/2020 to verify the resident's wishes in response to the noted discrepancy. The resident's electronic medical record and paper chart were updated to correspond appropriately. A full facility audit was conducted on 1/14/2020. R228 was the only resident to be impacted by the electronic medical record and paper chart not corresponding appropriately. Staff received re-education	

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21830	Continued From page 19 infection of the skin) of right upper limb, and sepsis (blood infection). The admission record also identified R228's advance directive as "Full Code" (person will allow all interventions needed to get their heart started). R228's admission Minimum Data Set (MDS), dated 12/30/19, identified R228 was cognitively intact and required extensive assistance for activities of daily living. Review of R228's electronic medical record included "Full Code" listed on the top of R228's initial page, and included a physician order, dated 12/24/19, identifying "Full Code." Review of R228's paper medical record included an Advance Directive Consent Form, dated and signed by R228 on 12/24/19, and signed by R228's physician on 12/26/19, which indicated R228's preference was "DNR (Do Not Resuscitate) In the event of witnessed cardiac or witnessed respiratory arrest, no cardiopulmonary resuscitation shall be initiated. In the event of sudden respiratory failure, endotracheal intubation (tubes placed from the mouth into the lungs) should not be done. This does not include emergency management in case of choking." During a review of R228's progress notes, dated 12/24/19, at 8:59 p.m. included, "Pt. [patient] signed DNR, waiting on MD signature." During an interview on 1/14/20, at 9:57 a.m. registered nurse (RN)-D stated, if a resident was found unresponsive, the paper chart included the official advance directive preference of the resident, would be the appropriate place to confirm the resident's code status.	21830	on appropriately capturing, updating and implementing residents' advance directive/code status wishes. Random chart audits will be completed to assure that resident's advance directive wishes are consistent within the electronic medical record to the wishes indicated on the Advance Directive form within the paper chart. These audits will be conducted weekly for one month, then monthly until the next "Quarterly Assurance" committee. The Director of Nursing 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 to determine the frequency for ongoing audits.	

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21830	Continued From page 20 During an interview on 1/14/20, at 9:58 a.m. RN-E stated, "We would always go by what's in the paper chart because that is what's been reviewed with family and the doctor." During an interview on 1/14/20, at 10:00 a.m. RN-H stated she would go to the paper medical record or to the electronic medical record, however, "I would always look at the signed form to make sure." When interviewed on 1/14/20, at 10:04 a.m. RN-F stated, "Their [residents] code status is right here, on PCC [Point Click Care] [electronic medical record utilized by the facility]," pointing to the initial page on R228's electronic medical record. RN-F stated, "That's where I always check. I look at their code status before I go into their room." During an interview on 1/14/20, at 10:05 a.m. RN-I stated, "I would go look at the paper chart because that's where the most current documentation would be." When interviewed on 1/14/20, at 11:36 a.m. R228 stated she remembered signing something, thought it was in the hospital, however, she wasn't sure. R228 indicated her preference was to not be resuscitated, because, when her husband passed away five months ago, she watched as emergency personnel attempted to resuscitate him. R228 stated, "I don't want that. I signed saying that they should just let me go. It's my time." During a follow up interview on 1/14/20, at 12:20 p.m. RN-F stated she had worked at the facility approximately seven months, and stated, "You are never alone when a code blue [universally recognized emergency code when someone	21830		

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stops breathing or has no pulse] happens. I have never been involved in one, but I know that the process is to call code blue on the walkie, and then several people respond. All of those people have a job. I'm not sure, but I think someone is in charge of verifying the code status. We all work together to do what the resident has determined."

When interviewed on 1/14/20, at 12:26 p.m. RN-G stated, "We check to see if they are breathing, alert the other staff, check code status in the patient's chart, the signed copy from the patient. They [paper chart and electronic medical record] should match, but the best place to verify that is in the [paper] chart. That always happens, in the event that it's a full resuscitation, start code blue procedure. Happens on all shifts, that is the process."

During an interview on 1/14/20, at 12:45 p.m. the director of nursing (DON) stated the process would include checking the paper chart in the event of someone being unresponsive, to verify their code status. DON indicated when a resident was admitted, the discharge orders from the hospital included the code status, and the admitting nurse always verifies that with the resident, using the Advance Directive Consent Form, and the resident signed the form and it was placed in the resident's paper chart. DON stated, "Health information staff and nursing work jointly to ensure changes get made in the record. They should always match."

Review of the facility's undated Code Blue Record, located on the facility's emergency cart (a wheeled container carrying medicine and equipment for use in emergency resuscitations), included, "CODE STATUS VERIFIED BY:" with a line for a signature. When interviewed on 1/14/20,

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21830	Continued From page 22 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 process...The RN Evening Supervisor will check orders for agreement between resident wishes and physician's order...Discussions with physician, resident, family members, and nursing staff need to be clearly documented...The 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." Review of the facility's policy, Code Blue-Cardiopulmonary Resuscitation, revised 4/14, included, "When a resident has a cardiac or respiratory arrest the resident's code status is immediately verified," however, the policy does not include direction as to what source should be used to verify the code status. SUGGESTED METHOD OF CORRECTION: The Administrator, Director of Nursing or designee, could develop, review, and/or revise policies and procedures to ensure resident preferences for advanced directives are honored and accurately identified. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.	21830		

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21830	Continued From page 23 TIME PERIOD FOR CORRECTION: Seven (7) days	21830		