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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MVG3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00399

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245501**

2.STATE VENDOR OR MEDICAID NO.
(L2) **849623400**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY**
(L4) **1907 KLEIN STREET**
(L5) **ST PETER, MN** (L6) **56082**

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) **10/01/2004**

6. DATE OF SURVEY **10/15/2021** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **79** (L18)

13.Total Certified Beds **79** (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
	79			
(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 :
Elizabeth Silkey, Unit Supervisor 10/28/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 10/28/2021 (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
11/01/1987
(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
10/19/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 28, 2021

CMS Certification Number (CCN): 245501

Administrator
Benedictine Living Community
1907 Klein Street
St Peter, MN 56082

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 October 15, 2021 the above facility is certified for:

79 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 79 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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 28, 2021

Administrator
Benedictine Living Community
1907 Klein Street
St Peter, MN 56082

RE: CCN: 245501
Cycle Start Date: August 12, 2021

Dear Administrator:

On October 15, 2021, the Minnesota Departments 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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MVG3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00399

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245501**

2.STATE VENDOR OR MEDICAID NO.
(L2) **849623400**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY**
(L4) **1907 KLEIN STREET**
(L5) **ST PETER, MN** (L6) **56082**

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) **10/01/2004**

6. DATE OF SURVEY **08/12/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **79** (L18)
13.Total Certified Beds **79** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	79			
(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 :
Julie Halvorson, HFE NE II 10/13/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 10/15/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1987
(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
(L33)

DETERMINATION APPROVAL

Electronically delivered
September 3, 2021

Administrator
Benedictine Living Community
1907 Klein Street
St Peter, MN 56082

RE: CCN: 245501
Cycle Start Date: August 12, 2021

Dear Administrator:

On August 12, 2021, 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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by November 12, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 12, 2022 (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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 On 8/9/21 to 8/12/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. 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.	E 000		
F 000	INITIAL COMMENTS On 8/9/21 to 8/12/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT 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: H5501030C (MN53584) and H5501035C (MN59965), however NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be UNSUBSTANTIATED: H5501034C (MN75546) H5501033C (MN75424 H5501032C (MN67698) H5501031C (MN66724) H5501036C (MN75493) The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

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

Electronically Signed | 09/13/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an assessment for safety by the multidisciplinary team was completed prior to self administration of medication (SAM) for 1 of 1 resident (R203) observed to use a nebulizer treatments through a nebulizer machine (inhalation of medication treatment). Findings include: R203's Face Sheet undated, indicated R203's diagnosis included chronic obstructive pulmonary disease (COPD). R203's physician orders printed 8/11/21, identified R203 was prescribed albuterol sulfate solution for nebulization; 2.5 mg (milligrams) /3 mL (milliliters) (0.083 %); amt: 3 mL; four times day for chronic obstructive pulmonary disease.	F 554	IDT reviewed residents care plan and most recent notes that state resident is competent and capable enough to make her own decisions. Spoke with Resident 203 who agreed that she would like to be able to complete her neb administration after staff set it up, but she did not feel the need to self-administer her other medications. Self-administration observation completed on 8/12/21 indicated that Resident 203 is able to maintain the integrity of the nebulizer mask throughout entire administration. IDT then collaborated with Mayo Hospice and PCP to obtain an order for Resident 203 to self-administer albuterol nebulizers after nurse set up. IDT and nursing staff will review resident 203□s ability to maintain self-administration abilities daily	9/24/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 554	Continued From page 2 R203's admission Minimum Data Set (MDS) assessment dated 8/4/21, indicated R203 was cognitively intact, required supervision with eating, and extensive assistance with all other activities of daily living. R203's Self-Administration of Medication Assessment dated 7/31/21, indicated R203 did not wish to self-administer medications while at the facility. When interviewed on 8/9/21, at 1:47 p.m. R203 indicated one day a male nurse had administered the resident's nebulizer via mask then left the room. R203 stated after a period of time she removed the mask; when the nurse returned to her room, he scolded her for taking the mask off and she put it back on. R203 indicated she then had the mask on for at least an hour. R203 further stated her supper arrived during that time and by the time the nebulizer mask was removed by a different staff her supper was cold; staff did not offer to replace the meal. On 8/11/21, at 11:57 a.m. trained medication aide (TMA)-A was observed setting up R203's nebulizer treatment while R203 was lying in bed. TMA-A applied the nebulizer via mask and told the resident she'd be back in a few minutes to remove it, then left the room. On 8/11/21, at approximately 12:05 p.m. TMA-A returned to R203's room and removed the nebulizer mask once the treatment was completed. When interviewed on 8/11/21, at 12:12 p.m. TMA-A stated R203 did not have an order	F 554	for one week with ongoing frequency and duration to be determined through analysis and review of the results. Observations will then be done quarterly and as needed based on Resident 203□s cognition and abilities. IDT will review all other residents who currently self-administer medications for competency to establish a consistent baseline, then begin quarterly and as needed reviews using the Self-Administration Observation. The Self-administration of medication process and policy was reviewed with nursing staff during the September 15 Nursing Meeting. Director of Nursing or designee will monitor self administration process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 554	Continued From page 3 indicating staff needed to stay in the room with her during administration of medication through a nebulizer. TMA-A further stated when staff needed to remain in the room with a resident receiving medication through a nebulizer it would be reflected in the order. TMA-A checked R203's orders and confirmed there was not a physician order for resident to self administer the nebulizer medication after set-up. TMA-A also checked the resident's care plan which did not indicate she could self administer medication. TMA-A stated she would check with other staff to see if she had missed the order. When interviewed on 8/11/21, at 12:35 p.m. TMA-A confirmed after further investigation that R203 did not have an order to self administer albuterol sulfate solution via nebulizer after set-up. When interviewed on 8/11/21, at 2:37 p.m. the director of nursing (DON) confirmed R203 would need to be assessed to be able to administer medication via nebulizer after set-up though was unaware a physician order was also needed. The policy titled Self-Administration of Medications, dated 2018, indicated: Residents have the right to self-administer medications if the interdisciplinary team has determined it is clinically appropriate and safe. The policy did not include the need to obtain a physician order prior to the resident self-administering medication.	F 554		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone,	F 576		10/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 576	Continued From page 4 including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 576	Wellness Director will complete a monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 576	Continued From page 5 facility failed to ensure mail was delivered to residents on Saturdays. This had the potential to affect all resident in the facility who received person mail, including but not limited to 9 of 9 residents (R3, R5, R9, R13, R18, R22, R25, R37), at the resident council meeting, who verbally confirmed not receiving mail on Saturdays. This had the potential to effect all 54 residents living in the facility. Findings include: On 8/10/21, at 10:33 a.m. to 11:00 a.m., a resident council interview was held with R3, R5, R9, R13, R18, R22, R25, R37, who routinely attended resident council meetings. When asked if they received their mail on Saturdays, R3 stated they did not, adding "weekends are long and lonely - getting mail would help." The other residents in attendance verified that mail was not delivered on Saturdays. During an interview on 8/11/21, at 7:39 a.m., health information coordinator (HIC)-D who was filling in at reception desk was asked how mail was delivered to facility. HIC-D stated the mailman came in and set the mail on the reception desk at the main entrance and staff from the activities department delivered it to residents. HIC-D confirmed mail was delivered to the facility in the same manner on Saturdays and added that housekeeping delivered it to residents. Housekeeper (H)-A who was listening to the conversation stated housekeeping only delivered newspapers; not mail. HIC-D then stated on Saturdays, mail is put in the administrative offices and delivered to residents on Mondays. During an interview on 8/11/21, at 8:40 a.m.	F 576	calendar assigning the person responsible for Saturday mail delivery. The monthly calendar will be posted in the main office. In addition, the calendar will be sent to the weekend supervisors. The incoming mail drop box is located at the reception desk by the front entrance. The postal carrier has been instructed to leave mail in the drop box. The designated person will be responsible to sort and deliver Residents mail on Saturday. Wellness Director or designee will audit mail delivery X 4 weeks and then quarterly with ongoing frequency and duration determined through analysis and review of findings. Will report through Resident Council and Quality meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 576	Continued From page 6 wellness director (WD)-A stated staff in the activities department (also known as the Wellness department) delivered mail during the week. If the mail came after they left for the day or if no activities staff where working, housekeeping delivered it, and that housekeeping delivered mail on Saturdays. During an interview on 8/11/21, at 8:50 a.m., environmental services director (EVS)-B was asked if housekeepers had a role in delivering newspapers and mails to residents. EVS-B stated they delivered newspapers, but not mail, adding that the activities staff delivered mail, "housekeepers wouldn't have time, we're short staffed." During an interview on 8/12/21, at 9:21 a.m., the administrator stated they didn't have enough staff to deliver mail on Saturdays, adding they had not been delivering mail on Saturdays for about a year; it stopped during the pandemic when residents were not able to come out of their rooms for activities. Prior to the pandemic, activities staff came in on Saturdays for an activity with residents and also delivered mail to residents. When activities staff stopped coming in for Saturday activities, mail delivery stopped too. "Mail delivery on Saturdays is a challenge...we'll brainstorm to come up with a plan." Facility Hospitality Guide dated 2020, indicated a residents mail would be delivered unopened, Monday through Saturday.	F 576		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to-	F 577		9/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 577	Continued From page 7 (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure state agency (SA) survey results for 9 of 9 residents (R3, R5, R9, R11, R13, R18, R22, R25, R37) who attended resident council, were readily accessible and were made aware of survey results. This had the potential to affect all 54 residents who resided in the facility. Findings include: On 8/10/21, from 10:33 a.m. to 11:00 a.m., a resident council group interview was held with R3, R5, R9, R11, R13, R18, R22, R25 and R37 who	F 577	The Survey binder has been relocated to another table by the main entrance. The binder is within wheelchair reach as it sits no more than 14 inches from the resident□s reach. The binder is clearly labeled State Survey Results on both the spine as well as the front of the binder. Residents were informed of the Survey binder's location at the 9-10-21 Resident Council meeting. Executive Director or Designee will audit placement of the binder monthly X 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 577	Continued From page 8 routinely attended resident council meetings. None of the nine residents were aware of the location of the SA survey results or that the results should be available to them for review. During an interview on 8/11/21, at 10:40 a.m. social services director (SSD)-A stated he was new to the facility and was not aware if the SA survey results were available to residents and resident representatives for review, and if they were, where they were located. During an interview on 8/11/21, at 10:50 a.m., when asked where the SA survey results were located, the administrator pointed to a white binder at the main entrance reception desk. When asked if a resident would be able to reach the binder, the administrator stated "They would have to ask for it" adding she would find another location for it. The binder was standing approximately 38 inches from the edge of the reception desk with no visible title. There was no policy addressing location of SA survey results.	F 577	months with ongoing frequency and duration to be determined through analysis and review of results. Residents will be reminded of the Survey Binder location/contents on a quarterly basis during Resident Council meetings.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		10/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 684	Continued From page 9 by: Based on interview and document review the facility failed to implement bowel movement (BM) protocol for 1 of 1 resident (R9) reviewed for constipation. Findings include: R9's quarterly Minimum Data Set (MDS) assessment dated 5/6/21, indicated resident was cognitively intact, required supervision with eating and extensive assistance with all other activities of daily living (ADL). The MDS further indicated R9 was frequently incontinent of bowel. R9's care plan printed 8/12/21, indicated an ADL goal to have regular bowel movements and directed staff to follow facility protocol. R9's physician orders printed 8/12/21, included an order for docusate sodium (a stool softener) 100 milligrams (mg) by mouth every morning and also as needed (PRN) up to three times a day. Review of R9's Vitals Report and Point of Care History report related to bowel movements indicated the following: - On 6/22/21, at 1:48 p.m., and at 2:13 p.m., R9 had a medium BM. R9's next documented BM was on 6/27/21, at 6:49 p.m.; 5 days later. - On 7/1/21, at 4:29 p.m. R9 had a large BM. R9's next documented BM was on 7/5/21, at 11:26 a.m.; 4 days later. - On 7/23/21, at 10:58 p.m. R9 had a large BM. R9's next documented BM was on 7/27/21, at 4:52 p.m.; 4 days later. R9 then went from	F 684	Beginning 8/12/21 Resident 9 has been given prune juice daily with breakfast along with current bowel regimen. Any refusals have been documented by nursing staff and Resident 9 has been satisfied with this plan and the results. During a facility wide review, IDT discovered that documentation of bowel movements have been found in two locations in the point of care charting; only one area contributing to the daily Resident Bowel Management Report. To improve the consistency in charting, one area (vitals area) of the POC will be activated to be charted on by NAR□s each shift for all residents in the facility. NAR□s were educated about this change in charting at the nursing staff meeting on 9/15/21. IDT also updated and aligned current BM protocol and house standing orders on 10/4/21 based on the recently improved tracking data. Protocol interventions to begin on day three of no recorded bowel movement and progress from there for all affected residents. Education about the updated protocol will be provided on 10/13/21 at the next nursing staff meeting. To ensure charting and protocol compliance Nurses, Nurse Managers and DON to monitor the reporting data weekly for one month. The plan and results in this charting and protocol change will be shared with the facility QA committee on September 16th (and again on 10/21/21) with ongoing frequency and duration to be determined through analysis and review of the results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 684	Continued From page 10 7/27/21, until 8/1/21 without a BM (5 days). And from 8/1/21, until 8/5/21 without a BM (4 days). Further review of R9's medical record did not include evidence of attempted interventions related to R9's constipation. When interviewed on 8/10/21, at 11:23 a.m. R9 stated having issues with constipation and only had a BM approximately once a week. R9 stated when still at home she took a black and white pill/stool softener and was able to have a BM daily. R9 further stated now takes an orange pill that doesn't do as good of a job. R9 stated staff informed her that it was the same type of stool softener but from a different company. R9 confirmed not liking to wait so long in between BM's as she didn't feel good when constipated. R9 further stated, it was a lot for the staff to clean up as she was incontinent. When interviewed on 8/12/21, at 9:50 a.m. nursing assistant (NA)-A confirmed all direct care staff were responsible for recording when a resident had a BM. NA-A stated if a resident went three days without a BM, the nurse would administer a suppository or other alternative intervention. NA-A confirmed it was the nurse's responsibility to monitor residents bowel movements. When interviewed on 8/12/21, at 10:12 a.m. licensed practical nurse (LPN)-A confirmed NA's and nursing would chart when a resident had a bowel movement and it was nursing's responsibility to monitor. LPN-A further confirmed that if a resident went three days without a bowel movement, staff would offer prune juice or whatever the resident had available prn.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 684	Continued From page 11 When interviewed on 8/12/21, at 10:39 a.m. registered nurse (RN)-A stated either NA's or nursing would document when a resident had a bowel movement. The nurse on the night shift was responsible for printing a BM report for the residents on their unit, and would either administer a suppository or prn stool softener, and pass the information on to the day staff. RN-A confirmed nursing would generally wait two to three days before initiating an intervention; three days for sure. RN-A confirmed the nurse should offer an intervention at least every three days if a resident had not had a BM. The policy titled, Bowel Protocol, dated June 2019, indicated: 1. Bowel management report will be run daily. 2. Nurse will refer to bowel protocol on day 3 of no bowel movement unless otherwise indicated. Day 3: Give/offer prune juice 8 oz (ounces) P.O. (by mouth) OR Miralax (a laxative) 17 gm (grams) in 8 oz of juice or water times one dose. Day 4: Administer/offer Dulcolax suppository (a laxative) per rectum (or biscodyl tabs 10 mg) and give/offer prune juice 8 oz OR offer Fleets enema (tap water enema with renal disease). May repeat Miralax 17 gm in 8 oz of juice or water daily times one dose. Day 5: Repeat day 4; assess bowel sounds (hypoactive), discomfort, bloating, vomiting, leakage; notify physician for further orders if any of the preceding were present. 3. Contact provider. 4. Nurse to document bowel assessment/movement in progress note and result in vitals section of electronic record.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F 688		10/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 688	Continued From page 12 §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to maintain and prevent loss of range of motion (ROM) for 1 of 2 residents (R22) reviewed for contractures and limited ROM. Findings include: R22's diagnosis (found in the medical record on the diagnosis report form) dated 8/5/21, included: hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) affecting the left side, muscle weakness and lymphedema (swelling in the arm or leg). R22's quarterly minimum data set (MDS) assessment dated 6/8/21, identified R22 as having a brief interview for mental status (BIMS) of "15" (meaning no impairment in cognition). The MDS identified R22 as requiring extensive	F 688	Collaborated with OT for PROM to left hand for Resident 22. Care plan updated on 8/14/21 to include staff to open left hand for PROM and wash with soap and water and dry well two times per day. This directive has been added to the Wing group sheet for all NAR□s to utilize. Resident 22, who in the past has refused splints to her left has agreed to complete her own PROM to LUE hand. Resident's□ compliance to this plan is documented in POC by NAR staff. IDT to monitor resident compliance weekly for 4 weeks, bi-weekly for 4 weeks, then monthly for two months. Resident compliance/noncompliance to be shared with OT for further recommendations. IDT to review and create a ROM plan for all residents for decreased ROM. Will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 688	Continued From page 13 assistance with activities of daily living (ADL's) that included dressing. The MDS indicated R22 had functional limitation one one side of the upper and lower extremities. R22's occupational therapy (OT) discharge progress notes dated 1/3/19, indicated R22 was discharged from OT with orders to wear a left palm protector at night. R22 had been evaluated for left sided weakness that included the left arm and hand. R22's OT discharge progress notes dated 1/9/20, indicated R22 was discharged from OT with orders to complete a restorative therapy (RT) program for passive range of motion (PROM) and active range of motion (AROM) to the left lower extremity (LLE) and left upper extremity (LUE) 2-3 days per week for 10 repetitions each. R22 had been evaluated for left sided weakness, related to left sided hemiplegia and hemiparesis. R22's OT discharge progress notes dated 2/25/20, indicated R22 was discharged from OT with orders to complete a ROM program (posted in residents room) and provide RT 2-3 days per week. R22 had been evaluated for left sided weakness, related to left sided hemiplegia and hemiparesis. R22's care plan dated 6/28/21, identified R22 as having a self care deficit related to cerebral inclusions (aggregates of misfolded proteins) and hemiplegia to the left side, requiring assistance with ADL's. Interventions included: staff to provide assistance with active and passive ROM 2-3 days per week (guidelines posted in R22's room). The care plan identified R22 as being oriented to person, place and time and long and short term	F 688	utilize functional limitation ROM observation, resident dx, and restorative nursing notes to complete review on admission and quarterly. Education about decreased ROM and current restorative plan discussed specifically at 9/15/21 nurse's meeting. On-going education regarding ROM and the revised restorative program to continue to be on a monthly basis. Facility currently part of a MN State PIPP grant focused on Restorative. Work continues throughout the facility to implement a facility wide restorative program. Staff education part of this grant as well as quarterly progress reports sent to Benedictine who in turns reports corporate progress to the state of MN.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 688	Continued From page 14	F 688		

memory is good. The care plan did not include R22's splint.

Review of the nursing assistant (NA) care sheet dated 8/11/21, did not include R22's active and passive ROM nor did it include R22's left hand splint.

Observation and interview on 8/9/21, at 1:30 p.m. R22's left arm and hand were noted to be flaccid and hanging between the wheelchair frame and buttocks. R22's left hand was clenched tightly. Interview with R22 at this time, stated her left arm and hand had been that way since her stroke, a few years ago. R22 attempted to manually open her hand and fingers, but could only partially open her hand, thumb and 2nd finger. R22's 3rd, 4th and 5th fingers remained clenched. R22 indicated she had not been receiving ROM and the left hand splint was occasionally applied at bedtime.

Further observation and interview on 8/10/21, at 2:00 p.m. R22 was sitting in the lounge visiting. R22's left arm and hand were hanging between the side of the wheelchair and buttocks. The arm was not supported. R22 could only lift her left arm to reposition partially. R22 had her left hand/fingers clenched tightly. R22 confirmed she had not received ROM nor was the splint applied to her left hand the evening before.

Observation on 8/10/21, at 2:15 p.m. R22's room noted to have a posting on the wall, that included directions and diagrams for providing PROM.

Interview on 8/11/21, at 11:00 a.m. nursing assistant (NA)-A indicated she was unsure if R22 received ROM. NA-A stated she had been providing cares for R22, but had not been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 688	Continued From page 15 providing ROM. NA-A verified there were instructions in R22's room on how to provide ROM, but did not think it was the NA's responsibility. NA-A further stated she was aware of R22's splint to the left hand, because it was in her room. NA-A did not know when R22 was suppose to wear the splint. Interview on 8/11/21, at 11:00 a.m. licensed practical nurse (LPN)-A stated she was not aware of R22 receiving ROM, and thought a splint had been tried but was discontinued. LPN-A thought it had been a couple of years since it had been discontinued. LPN-A confirmed the nursing staff had not been providing ROM for R22, and was unsure it was being done. Interview on 8/10/21, at 2:00 p.m., nurse manager (NM)-B indicated she was unsure if R22 had been receiving ROM or wearing the left hand splint. NM-B did not think the nursing staff were responsible for providing this treatment. NM-B further indicated the facility did have a restorative aid in the past, but that person had not been employed for several months. Interview on 8/11/21, at 12:30 p.m. occupational therapist (OT)-A indicated OT had been evaluating R22 throughout the years for different concerns. OT-A confirmed the above OT discharge progress note recommendations, related to R22's left hand splint and ROM needs. OT-A confirmed the facility staff should be providing these preventive interventions for R22. A policy was requested for restorative therapy (RT), but not provided.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance	F 692		9/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 692	Continued From page 16 CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess impaired nutritional status and weight loss to implement approaches to maintain acceptable nutritional parameters for 1 of 2 residents (R29) who had a significant weight loss of 15 pounds (#) in a 6 1/2 week period. Findings include: R29 was admitted to the facility on 6/11/21, with diagnosis (found on the diagnosis report) dated 8/3/21, including: malignant neoplasm of the bronchus, (cancer in the lungs), dysphagia	F 692	Registered Dietician met with R29 regularly over the course of the next several weeks to review menus and assist R29 with picking food choices that were consistent with an IDDSI 5 diet. R29 was offered food, beverage, and supplement choices as tolerated with R29's diet. Resident refusals were documented. On 8-27-21, R29 admitted to hospice where both the RD and hospice RN continued to document the offering of food, beverage, and supplements and continued resident refusal to eat. R29 passed away on hospice on 9-10-21.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 692	Continued From page 17 (language disorder), neutropenia (low white blood cell count) protein calorie malnutrition (inadequate intake of food protein), hyponatremia (sodium in the blood is too low) and chronic kidney disease (gradual loss of kidney function). R23's admission minimal data set (MDS) assessment dated 6/16/21, identifies R29 as having a brief interview of mental status (BIMS) of "15" (meaning cognitively intact). The MDS identified R29 as having difficulty with swallowing. The MDS also identified R29 as having a weight loss of 5% or more in the past month. R29 receives a mechanically altered diet and eats approximately 25% of meals. R23's nutritional assessment dated 6/14/21, completed by the facility dietician, indicated R29 was on a regular diet as tolerated and receives soft moistened foods and small bite size pieces of food. R29 requests small portions. The assessment also included snacks and ensure supplement between meals. Weight is 131#. R29's care plan identified being at risk for alteration in nutrition related to terminal cancer of the bronchial and lung. R29 has difficulty with swallowing. R29 eats independently after set up and receives a room tray. R29 prefers small food portions and prefers bite size food. The care plan indicated R29 receives dietary supplements of his choice 3 times daily for extra calories, nutrients and protein as tolerated. R29's weight on admission was 131# (6/11/21), and 117# on 7/15/21. R29's ideal body weight (IBW) is 144-176#. Review of R29's monthly weights from 6/11/21, to 7/27/21, identified the following:	F 692	All new admits are weighed upon admission and then weekly or as needed with change in condition. Registered Dietician will follow up with nursing staff to assure weights are taken and recorded correctly upon admission. Registered Dietician will implement an Unplanned Weight Loss worksheet and a tracking form for supplements. This will allow for the monitoring of unplanned weight loss and supplement usage for all residents. The RD will attend IDT meetings to review all residents with significant weight changes to gain interdisciplinary feedback on the effectiveness of weight loss interventions including supporting documentation of supplemental administration and resident refusal of supplements. Through the supplement tracking form, the RD will be able to follow up on and document residents□ refusal of supplements and make changes as appropriate. Weight variance report will be audited weekly for one month, then bi-weekly for one month then monthly for two months. RD to report on residents with significant weight changes at our monthly Quality Meetings with ongoing frequency and duration to be determined through analysis and review of the results. Registered Dietician or designee to monitor process. Nursing staff were educated on the new process at the September 15,2021 monthly nursing meeting. On-going	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 692	Continued From page 18 6/11/21, weight 131# 7/15/21, weight 117# 7/27/21, weight 116# There were no progress notes or assessments done when R29 exhibited a significant weight loss from 6/11 to 7/15/21, of 14# (within a month) and continued to lose weight on 7/27/21. Review of a physician progress note dated 7/9/21, indicated R29 is comfort care, but requests antibiotic treatment and IV hydration if needed. The note further indicated, although R29 is expected to exhibit some weight loss due to comorbidities, continue with nutritional supplements as needed. R29's physicians orders dated 8/11/21, included orders for a clear ensure supplement at breakfast (with medication pass) and strawberry ensure at dinner (with medication pass). Interview and observation on 8/9/21, at 5:40 p.m. R29 was laying in bed eating supper. R29 was eating independently and had eaten most of his meal. R29 had no problems with swallowing at that time. R29 did not have a nutritional supplement offered or present at this time. R29 indicated he had not been offered a nutritional supplement, at least in the past 3 days. R29 further stated staff would give him a strawberry supplement, of which he preferred a different flavor. R29 confirmed the facility staff had not offered him any other kind of supplement. Interview with licensed practical nurse (LPN)-A on 8/9/21, at 6:00 p.m. confirmed she had not been giving R29 a nutritional supplement with the	F 692	education will be provided as needed at monthly nursing meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 692	Continued From page 19	F 692		

breakfast and dinner medication pass. LPN-A indicated she did not think R29 liked the supplement when it was offered.

Observation of the medication pass on 8/10/21 and 8/11/21, at breakfast and dinner, did not include a supplement as ordered. The medical record lacked documentation of any type of supplement being offered for R29's weight loss

Interview with registered nurse (RN)-A on 8/11/21, at 1:00 p.m. confirmed the medical record did not indicate whether R29 was receiving a nutritional supplement during the medication passes. RN-A thought R29 may have been refusing it in the past, but was unsure.

Interview with the facility dietary manager (DM) on 8/11/21 at 2:00 p.m. indicated she was aware of R29's significant weight loss, but stated the facility dietician monitors and addresses's residents weight. The DM also indicated there was no communication related to R29's weight loss or additional interventions implemented when R22's weight loss was identified.

Interview with nurse manager (NM)-B on 8/11/21, at 2:15 p.m. indicated she was aware of R29's significant weight loss, but was unsure if there were any additional interventions implemented. NM-A further indicated she was not aware R29 was currently not being offered a nutritional supplement, during medication administration.

Interview with the facility licensed dietician (LD), on 8/11/21, at 2:30 p.m. indicated she was not aware of R29's significant weight loss. The LD indicated she reviews resdient's weights frequently, but did not identify R29's weight loss.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 692	Continued From page 20 The LD indicated she failed to compare R29's admission weight to the weights obtained at the facility. The LD further stated R29's nutritional supplement should have been monitored more closely, to assure he was receiving the supplement as ordered. The RD indicated she would have increased R29's nutritional supplement, if the weight loss would have been identified. A policy was requested for weight loss, but not provided.	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**08/11/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET** **ST PETER, MN 56082**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/11/2021. At the time of this survey, BENEDICTINE LIVING 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/10/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**08/11/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET** **ST PETER, MN 56082**

(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 Healthcare 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 detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. BENEDICTINE LIVING COMMUNITY is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 2006 and was determined to be of Type V (111) construction. Also in 2006 and addition was constructed and was determined to be of Type V (111) construction - the addition included a link corridor to the hospital. The nursing home is separated from a hospital	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**08/11/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 2 and a senior housing facility by 2-hour fire wall assemblies, with opening protectives consisting of labeled, self-closing, positive latching, 90-minute fire rated door assemblies. Because the original building and addition meet the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors which is monitored for automatic fire department notification. The facility also has automatic smoke detection in all sleeping rooms which is interconnected to the nurse call system. The facility has a capacity of 79 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 271 SS=D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7	K 271		8/20/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**08/11/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 271	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the exit discharge in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.2.7, 7.1.7, 7.7. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 08/11/2021 between 10:00 AM to 03:00 PM, it was revealed that the exit door in the " EAGLE " corridor had a vertical transition to grade greater than a one-half inch - associated with the concrete separating where the building is settling. This deficient condition was confirmed by the Facility Maintenance Director at the time of discovery.	K 271	Concrete slab was mudjacked and now is level. EVS or designee will complete quarterly audit of walking surfaces at discharge exits x 2 with reporting of findings to Safety Committee. If there are no adverse findings, move to semi-annual audit with report to Safety Committee.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under	K 324		8/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**08/11/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 324	Continued From page 4 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the safety and security related to a cooking appliance in a resident accessible corridor in accordance with the Life Safety Code NFPA 101, 2012 edition, section 19.3.2.5.3. This deficient condition could have an isolated impact on the residents within the facility. Findings Include: On 08/11/2021 between 10:00 AM to 03:00 PM, it was revealed during the walk-through of the facility that in the Physical Therapy / Occupational Therapy Room (C323-A), the stove was found to be in an active and functioning state, having no lock-out capabilities. This deficient condition was confirmed by the Facility Administrator at the time of discovery.	K 324	A lock-out kill switch has been added to the stove in the Physical Therapy room. Therapy staff or other designated person to audit for lock-out kill switch to be in locked position monthly X 4 with reporting of findings to the Safety Committee. If there are no negative findings, move to annual auditing.	
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	K 345		8/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**08/11/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 345	Continued From page 5 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 staff interview, the facility failed to maintain the fire alarm system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.6.2.7, and NFPA 72 (2010 edition) National Fire Alarm and Signal Code, sections 14.1.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/11/2021 between 10:00 AM to 03:00 PM, it was revealed during documentation review that the annual fire alarm system inspection report noted items in need of repair or replacement. No documentation was provided to confirm the vendor had completed repairs or replacement and that devices were functioning. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 345	The two smoke detectors were replaced by our vendor on 8/17/21. Smoke detectors will be checked on an on-going basis by EVS Director or designee and replaced as appropriate. EVS Documentation of quarterly smoke detector checks with reporting of check completion to the Safety Committee quarterly on a routine basis.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection,	K 353		8/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**08/11/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 353	Continued From page 6 Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review, and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.6, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2, 5.2.1.1.1, 5.2.1.1.2, 5.2.1.1.4, 5.2.1.2. NFPA13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.5.6, 8.5.6.1. These deficient conditions could have a widespread impact on the residents within the facility. Findings include: 1. On 08/11/2021, between 10:00 AM to 03:00 PM, it was revealed the sprinkler head in the housekeeping closet (C330) could not be physically located. 2. On 08/11/2021, between 10:00 AM to 03:00	K 353	1. Sprinkler head was located by EVS Director 2. Sprinkler head with corrosion was replaced by Olympic Fire Protection 3. Quarterly inspections will be completed by EVS Director or designee and be documented. This will be monitored through our Safety Committee meetings on a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**08/11/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 353	Continued From page 7 PM, it was revealed the sprinkler head in A136 exhibited signs of corrosion and oxidation. 3. On 08/11/2021 between 10:00 AM to 03:00 PM; it was revealed during documentation review that no sprinkler system quarterly inspection records were available for review for the 1st, 3rd, and 4th quarters of the calendar year. These deficient conditions were confirmed by the Facility Maintenance Director at the time of discovery.	K 353		
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper physical accessibility and depth of working space to electrical panel(s) in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 70 (2011 edition), National Electrical Code, section 110.26, and NFPA 99, (2012 edition), Health Care Facilities Code, section 6.3.2.1. This deficient condition	K 511	This room has been cleared of all storage racks and subsequent materials. EVS Director or designee will monitor space to assure compliance with physical accessibility and space in front of electrical panels. Mark 30" spacing from electrical box with yellow tape. Create task in TELS system	8/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**08/11/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 511	Continued From page 8 could have a widespread impact on the residents within the facility. Findings include: On 08/11/2021 between 10:00 AM to 03:00 PM, it was revealed that electrical panel(s) located in C316 were obstructed by general storage (metal storage rack containing combustible materials) which reduced the clearance to less than the required clearance of 3 feet minimum. This deficient condition was confirmed by the Maintenance Director at the time of discovery.	K 511	that prompts monthly observations and documentation of area and ongoing presence of clearance markings.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to randomly conduct fire drills in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.7.6. This deficient condition could have a widespread impact on the residents within the facility.	K 712	EVS Director is fairly new and was not aware of the varying time requirement on our monthly drills. Going forward, fire drill times will be varied in accordance with the regulation. This will be monitored through our	9/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**08/11/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 712	Continued From page 9 Findings include: On 08/11/2021 between 10:00 AM to 03:00 PM, it was revealed during documentation review that the times were not varied for the fire drills conducted on 2nd and 3rd shifts for the 1st through the 4th quarters of the calendar year. This deficient condition was confirmed by the Facility Maintenance Director at the time of discovery.	K 712	monthly Safety Committee meetings. Completed 9-30-21	
K 781 SS=F	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to have a documented policy associated with the prohibition of portable space-heating devices accordance with the Life Safety Code NFPA 101, 2012 edition, section 19.7.8. This deficient condition could have a widespread impact on the residents within the facility. Findings Include: On 08/11/2021 between 10:00 AM to 03:00 PM, it was revealed during document review that no document was available for review associated to	K 781	Space heater policy was updated to allow space heaters in administrative offices. Space heaters are not allowed in resident sleeping areas or living spaces including the nurses' stations. EVS of designee to complete quarterly audits of 4 resident rooms and common areas, 1 Neighborhood per quarter. This audit will include checking for presence of space heaters. Audit findings will be shared quarterly to the Safety Committee. If non-compliance found, RCA to be completed to help determine next steps.	9/15/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**08/11/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 781	Continued From page 10 the prohibition of portable space-heating devices This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 781	Staff were re-educated on the space heater policy. Completed 9/15/21	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to document the annual electrical receptacle testing in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.3.2, 6.3.4.1, and 6.3.4.2. This deficient condition could have a widespread	K 914	While tests were performed, documentation was not available due to change in Maintenance personnel. Testing will continue to be completed and documented and kept in readily accessible file.	9/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**08/11/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 914	Continued From page 11 impact on the residents within the facility. Findings include: On 08/11/2021 between 10:00 AM to 03:00 PM, it was revealed during documentation review that no records were available to review related to the electrical outlet testing in resident rooms. This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 914	EVS Director or designee to monitor for compliance. Findings will be reviewed at Safety Committee.	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	K 920		9/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**08/11/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 920	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage the implementation and usage of power strips in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D). These deficient conditions could have a widespread impact on the residents within the facility. Findings include: 1. On 08/11/2021 between 10:00 AM to 03:00 PM, it was revealed on the walk-thru of the facility that extension cords were in use in the following locations: D406 / B232 / outside of B232 / D432 / C310 / E525 / Eagle Wing - Nurses Station / F609. 2. On 08/11/2021 between 10:00 AM to 03:00 PM, it was revealed on the walk-thru of the facility that appliances were connected to power-strips in the following locations: B237 / Main Office Area. 3. On 08/11/2021 between 10:00 AM to 03:00 PM, it was revealed on the walk-thru of the facility that a multi-tap adapter was in use in F609. These deficient conditions were confirmed by the Maintenance Director at the time of discovery.	K 920	1. Extension cords have been removed 2. Power strip removed and appliance plugged directly into outlet. 3. Multi-tap adapter has been removed. Will re-educate staff on use of power strips. Will continue to do facility walk thru to audit for inappropriate use of power strips and/or extension cords. Staff will be educated to remove any extension cords and report to EVS Director or designee. Safety audits will be completed on a regular basis. Audit findings will be report through our Safety Committee.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and	K 923		9/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**08/11/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 923	Continued From page 13 ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store and secure med gas cylinders in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.4, and	K 923	Signage has been provided in the room designating full/empty E tanks storage. EVS Director or other designee to audit O2 rooms monthly X 3 then every 6	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**08/11/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 923	Continued From page 14 NFPA 99 (2012 edition), Health Care Facilities Code, section 11.3, 11.6.5. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/11/2021 between 10:00 AM to 03:00 PM, it was revealed on the walk-thru of the facility that the Med Gas (O2) storage rooms did not contain interior wall signage to identify empty/full locations for cylinders and did not have rack storage for empty/full cylinders. This deficient condition was confirmed by the Maintenance Director at the time of discovery.	K 923	months with reporting of findings to the Safety Committee. If no adverse findings, then move to annual auditing. The E tanks are brought in by hospice for hospice residents. We will have the hospice oxygen supplier provide a storage rack in which to store full and empty Oxygen E tanks.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to implement a medical gas qualification and staff training program in accordance with the NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.1.1, 11.5.2.1.2, 11.5.2.1.3, and 11.5.2.1.4 This deficient condition could have a widespread	K 926	Oxygen equipment competencies were completed on certified nursing assistants during 9-8-21 Skills Fair. Competency Checklists will be completed annually on all nursing staff and during new hire orientation.	9/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**08/11/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(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 926	Continued From page 15 impact on the residents within the facility. Findings Include: On 08/11/2021 between 10:00 AM to 03:00 PM, it was revealed during document review that the documentation provided for review, related to staff Med Gas (O2) training - associated to time of employee hire -or- subsequent refresher training, was inconclusive. This deficient condition was confirmed by the Facility Maintenance Director at the time of discovery.	K 926	Staff Development RN will perform competency checks and maintain documentation of training and competencies.	
K 927 SS=D	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the medical gas storage and transfill room ventilation fan in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.4, and NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.3,	K 927	A HVAC Contractor has been contacted to repair the exhaust fan. EVS director or designee will monitor Oxygen Room exhaust fans to ensure the fans are operating and report to Safety committee on quarterly basis.	10/15/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**08/11/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET** **ST PETER, MN 56082**

(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 927	Continued From page 16 NFPA 55 (2010 edition), Compressed Gases and Cryogenic Fluids Code, section 6.5. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 08/11/2021 between 10:00 AM to 03:00 PM, it was revealed on the walk-thru of the facility, that it could not be confirmed that the exhaust fan in RM D433 (Med Gas / Transfill Rm) was functioning properly This deficient condition was confirmed by the Maintenance Director at the time of discovery.	K 927		

Electronically delivered
September 3, 2021

Administrator
Benedictine Living Community
1907 Klein Street
St Peter, MN 56082

Re: State Nursing Home Licensing Orders
Event ID: MVG311

Dear Administrator:

The above facility was surveyed on August 9, 2021 through August 12, 2021 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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00399	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/9/21, to 8/12/21, a licensing and complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00399	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were found to be SUBSTANTIATED: H5501030C (MN53584) and H5501035C (MN59965), however NO licensing orders were issued. The following complaints were found to be UNSUBSTANTIATED: H5501034C (MN75546) H5501033C (MN75424 H5501032C (MN67698) H5501031C (MN66724) H5501036C (MN75493) 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00399	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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		
2 385	MN Rule 4658.0200 Subp. 3 Policies Concerning Residents; Mail Subp. 3. Mail. A resident must receive mail unopened unless the resident or the resident's legal guardian, conservator, representative payee, or other person designated in writing by the resident has requested in writing that the mail be reviewed. The outgoing mail must not be censored. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure mail was delivered to residents on Saturdays. This had the potential to affect all resident in the facility who received person mail, including but not limited to 9 of 9 residents (R3, R5, R9, R13, R18, R22, R25,	2 385	corrected	9/24/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00399	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	1907 KLEIN STREET ST PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 385	Continued From page 3 R37), at the resident council meeting, who verbally confirmed not receiving mail on Saturdays. This had the potential to effect all 54 residents living in the facility. Findings include: On 8/10/21, at 10:33 a.m. to 11:00 a.m., a resident council interview was held with R3, R5, R9, R13, R18, R22, R25, R37, who routinely attended resident council meetings. When asked if they received their mail on Saturdays, R3 stated they did not, adding "weekends are long and lonely - getting mail would help." The other residents in attendance verified that mail was not delivered on Saturdays. During an interview on 8/11/21, at 7:39 a.m., health information coordinator (HIC)-D who was filling in at reception desk was asked how mail was delivered to facility. HIC-D stated the mailman came in and set the mail on the reception desk at the main entrance and staff from the activities department delivered it to residents. HIC-D confirmed mail was delivered to the facility in the same manner on Saturdays and added that housekeeping delivered it to residents. Housekeeper (H)-A who was listening to the conversation stated housekeeping only delivered newspapers; not mail. HIC-D then stated on Saturdays, mail is put in the administrative offices and delivered to residents on Mondays. During an interview on 8/11/21, at 8:40 a.m. wellness director (WD)-A stated staff in the activities department (also known as the Wellness department) delivered mail during the week. If the mail came after they left for the day or if no activities staff where working, housekeeping delivered it, and that housekeeping	2 385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00399	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	1907 KLEIN STREET ST PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 385	Continued From page 4 delivered mail on Saturdays. During an interview on 8/11/21, at 8:50 a.m., environmental services director (EVS)-B was asked if housekeepers had a role in delivering newspapers and mails to residents. EVS-B stated they delivered newspapers, but not mail, adding that the activities staff delivered mail, "housekeepers wouldn't have time, we're short staffed." During an interview on 8/12/21, at 9:21 a.m., the administrator stated they didn't have enough staff to deliver mail on Saturdays, adding they had not been delivering mail on Saturdays for about a year; it stopped during the pandemic when residents were not able to come out of their rooms for activities. Prior to the pandemic, activities staff came in on Saturdays for an activity with residents and also delivered mail to residents. When activities staff stopped coming in for Saturday activities, mail delivery stopped too. "Mail delivery on Saturdays is a challenge...we'll brainstorm to come up with a plan." Facility Hospitality Guide dated 2020, indicated a residents mail would be delivered unopened, Monday through Saturday. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and update policies regarding resident's mail. The administrator of designee could educated staff regarding policies and procedures to ensure all residents receive their mail as delivered, including on weekends. The administrator or designee, could conduct audits of mail delivery. The administrator or designee could take results of audits to QAPI to determine the need for further education/monitoring/compliance.	2 385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00399	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 385	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 385		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to maintain and prevent loss of range of motion (ROM) for 1 of 2 residents (R22) reviewed for contractures and limited ROM. Findings include: R22's diagnosis (found in the medical record on the diagnosis report form) dated 8/5/21, included: hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) affecting the left side, muscle weakness and	2 890	Corrected	9/24/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00399	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	1907 KLEIN STREET ST PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 6 lymphedema (swelling in the arm or leg). R22's quarterly minimum data set (MDS) assessment dated 6/8/21, identified R22 as having a brief interview for mental status (BIMS) of "15" (meaning no impairment in cognition). The MDS identified R22 as requiring extensive assistance with activities of daily living (ADL's) that included dressing. The MDS indicated R22 had functional limitation one one side of the upper and lower extremities. R22's occupational therapy (OT) discharge progress notes dated 1/3/19, indicated R22 was discharged from OT with orders to wear a left palm protector at night. R22 had been evaluated for left sided weakness that included the left arm and hand. R22's OT discharge progress notes dated 1/9/20, indicated R22 was discharged from OT with orders to complete a restorative therapy (RT) program for passive range of motion (PROM) and active range of motion (AROM) to the left lower extremity (LLE) and left upper extremity (LUE) 2-3 days per week for 10 repetitions each. R22 had been evaluated for left sided weakness, related to left sided hemiplegia and hemiparesis. R22's OT discharge progress notes dated 2/25/20, indicated R22 was discharged from OT with orders to complete a ROM program (posted in residents room) and provide RT 2-3 days per week. R22 had been evaluated for left sided weakness, related to left sided hemiplegia and hemiparesis. R22's care plan dated 6/28/21, identified R22 as having a self care deficit related to cerebral inclusions (aggregates of misfolded proteins) and	2 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00399	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	1907 KLEIN STREET ST PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 7 hemiplegia to the left side, requiring assistance with ADL's. Interventions included: staff to provide assistance with active and passive ROM 2-3 days per week (guidelines posted in R22's room). The care plan identified R22 as being oriented to person, place and time and long and short term memory is good. The care plan did not include R22's splint. Review of the nursing assistant (NA) care sheet dated 8/11/21, did not include R22's active and passive ROM nor did it include R22's left hand splint. Observation and interview on 8/9/21, at 1:30 p.m. R22's left arm and hand were noted to be flaccid and hanging between the wheelchair frame and buttocks. R22's left hand was clenched tightly. Interview with R22 at this time, stated her left arm and hand had been that way since her stroke, a few years ago. R22 attempted to manually open her hand and fingers, but could only partially open her hand, thumb and 2nd finger. R22's 3rd, 4th and 5th fingers remained clenched. R22 indicated she had not been receiving ROM and the left hand splint was occasionally applied at bedtime. Further observation and interview on 8/10/21, at 2:00 p.m. R22 was sitting in the lounge visiting. R22's left arm and hand were hanging between the side of the wheelchair and buttocks. The arm was not supported. R22 could only lift her left arm to reposition partially. R22 had her left hand/fingers clenched tightly. R22 confirmed she had not received ROM nor was the splint applied to her left hand the evening before. Observation on 8/10/21, at 2:15 p.m. R22's room noted to have a posting on the wall, that included directions and diagrams for providing PROM.	2 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00399	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 8 Interview on 8/11/21, at 11:00 a.m. nursing assistant (NA)-A indicated she was unsure if R22 received ROM. NA-A stated she had been providing cares for R22, but had not been providing ROM. NA-A verified there were instructions in R22's room on how to provide ROM, but did not think it was the NA's responsibility. NA-A further stated she was aware of R22's splint to the left hand, because it was in her room. NA-A did not know when R22 was suppose to wear the splint. Interview on 8/11/21, at 11:00 a.m. licensed practical nurse (LPN)-A stated she was not aware of R22 receiving ROM, and thought a splint had been tried but was discontinued. LPN-A thought it had been a couple of years since it had been discontinued. LPN-A confirmed the nursing staff had not been providing ROM for R22, and was unsure it was being done. Interview on 8/10/21, at 2:00 p.m., nurse manager (NM)-B indicated she was unsure if R22 had been receiving ROM or wearing the left hand splint. NM-B did not think the nursing staff were responsible for providing this treatment. NM-B further indicated the facility did have a restorative aid in the past, but that person had not been employed for several months. Interview on 8/11/21, at 12:30 p.m. occupational therapist (OT)-A indicated OT had been evaluating R22 throughout the years for different concerns. OT-A confirmed the above OT discharge progress note recommendations, related to R22's left hand splint and ROM needs. OT-A confirmed the facility staff should be providing these preventive interventions for R22.	2 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00399	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	1907 KLEIN STREET ST PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 9 A policy was requested for restorative therapy (RT), but not provided. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure all residents with limitations in range of motion receive services to maintain or improve range of motion function. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an assessment for safety by the multidisciplinary team was completed prior to self administration of medication (SAM) for 1 of 1 resident (R203) observed to use a nebulizer treatments through a nebulizer machine (inhalation of medication treatment). In addition, the facility failed to obtain a written order from the physician for SAM.	21565	corrected	9/24/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00399	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	1907 KLEIN STREET ST PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21565	Continued From page 10 Finding include: R203's Face Sheet undated, indicated R203's diagnosis included chronic obstructive pulmonary disease (COPD). R203's physician orders printed 8/11/21, identified R203 was prescribed albuterol sulfate solution for nebulization; 2.5 mg (milligrams) /3 mL (milliliters) (0.083 %); amt: 3 mL; four times day for chronic obstructive pulmonary disease. R203's admission Minimum Data Set (MDS) assessment dated 8/4/21, indicated R203 was cognitively intact, required supervision with eating, and extensive assistance with all other activities of daily living. R203's Self-Administration of Medication Assessment dated 7/31/21, indicated R203 did not wish to self-administer medications while at the facility. When interviewed on 8/9/21, at 1:47 p.m. R203 indicated one day a male nurse had administered the resident's nebulizer via mask then left the room. R203 stated after a period of time she removed the mask; when the nurse returned to her room, he scolded her for taking the mask off and she put it back on. R203 indicated she then had the mask on for at least an hour. R203 further stated her supper arrived during that time and by the time the nebulizer mask was removed by a different staff her supper was cold; staff did not offer to replace the meal. On 8/11/21, at 11:57 a.m. trained medication aide (TMA)-A was observed setting up R203's nebulizer treatment while R203 was lying in bed. TMA-A applied the nebulizer via mask and told the resident she'd be back in a few minutes to	21565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00399	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	1907 KLEIN STREET ST PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21565	Continued From page 11 remove it, then left the room. On 8/11/21, at approximately 12:05 p.m. TMA-A returned to R203's room and removed the nebulizer mask once the treatment was completed. When interviewed on 8/11/21, at 12:12 p.m. TMA-A stated R203 did not have an order indicating staff needed to stay in the room with her during administration of medication through a nebulizer. TMA-A further stated when staff needed to remain in the room with a resident receiving medication through a nebulizer it would be reflected in the order. TMA-A checked R203's orders and confirmed there was not a physician order for resident to self administer the nebulizer medication after set-up. TMA-A also checked the resident's care plan which did not indicate she could self administer medication. TMA-A stated she would check with other staff to see if she had missed the order. When interviewed on 8/11/21, at 12:35 p.m. TMA-A confirmed after further investigation that R203 did not have an order to self administer albuterol sulfate solution via nebulizer after set-up. When interviewed on 8/11/21, at 2:37 p.m. the director of nursing (DON) confirmed R203 would need to be assessed to be able to administer medication via nebulizer after set-up though was unaware a physician order was also needed. The policy titled Self-Administration of Medications, dated 2018, indicated: Residents have the right to self-administer medications if the interdisciplinary team has determined it is clinically appropriate and safe. The policy did not	21565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00399	A. BUILDING: _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	**1907 KLEIN STREET ST PETER, MN 56082**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21565	Continued From page 12 include the need to obtain a physician order prior to the resident self-administering medication. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies for self administration of medication. The DON or designee could inservices staff regarding policies and procedures and process for determination of resident capability to safely self-administer medications and ensure physician order is obtained for individual resident to self administer medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance. The DON or designee could take results of audits to QAPI to determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21565		