Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 18, 2024

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

RE: CCN: 245501
Cycle Start Date: October 30, 2024

Dear Administrator:

On December 17, 2024, 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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 18, 2024

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

RE: CCN: 245501
Cycle Start Date: October 30, 2024

Dear Administrator:

On October 30, 2024, 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
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 January 30, 2025 (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 April 30, 2025 (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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245501	A. BUILDING: _____ B. WING _____	10/30/2024

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245501	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 10/30/2024

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 1

and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to ensure written transfer notice was provided to the resident and resident representative following a facility-initiated transfer to the hospital for 1 of 2 residents (R33) reviewed for hospitalization.

Findings include:

R33's Face Sheet printed 10/30/24, included diagnoses of osteomyelitis (infection in the bone) of left ankle and foot, acute respiratory failure with hypoxia (not enough oxygen or too much carbon dioxide), heart failure and diabetes mellitus.

R33's significant change Minimum Data Set (MDS) dated 8/28/24, indicated R33 had intact cognition, understands and is understood.

Review of R33's electronic medical record (EMR) included recent hospitalizations on 9/19/24 returning 9/24/24, 10/13/24 returning 10/15/24 and 10/21/24 returning 10/30/24.

During interview on 10/29/24 at 12:50 p.m., licensed practical nurse (LPN)-C indicated she is a new employee at the facility so is not sure what the process for transfer to the hospital but could find out.

During interview on 10/29/24 at 1:02 p.m., LPN-A indicated the protocol for transfer to the hospital includes notification of the family, and generally ask if they want the bed held or not, and print out the Notice of Resident/Patient Transfer or Discharge form and put it in the packet of medical records, which gets sent to the hospital. LPN-A indicated they do not provide any documents to the patients or the family member (if present) unless requested.

During interview on 10/29/24 at 12:54 p.m., LPN-B indicated she isn't sure what the transfer process is and would have to ask the unit manager.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245501	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 10/30/2024

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 2 Review of R33's Notice of Resident/Patient Transfer or Discharge form dated 9/18/24 and 10/21/24, included the reason for transfer or discharge was necessary for the resident's welfare and the resident's needs cannot/could not be met in the facility. The notice was an immediate transfer or discharge which was required by the resident's urgent medical needs. Date of notice was 9/18/24 and 10/21/24. The form lacked a specific reason for the transfer or discharge. The EMR lacked a transfer notice for 10/13/24 - 10/15/24 hospitalization. During interview on 10/29/24 at 1:32 p.m., registered nurse (RN)-B, also identified as unit manager, indicated a Notice of Transfer and Bed hold are completed and printed out. A copy is sent with the resident information in the packet. RN-B confirmed there is a rationale for the discharge on the transfer notice, but no specific reason such as short of breath on the form. During interview on 10/30/24 at 9:16 a.m., R33 (returned to the facility on 10/29/24) stated he doesn't remember getting any papers when he went to the hospital. R33 thought he went to the hospital because of the infection in his foot but found out when he got there he was there for pneumonia instead. During interview on 10/30/24 at 11:01 a.m., the director of nursing (DON) indicated the bed hold is given to the resident but in the packet of information is given to EMS and handed to the hospital staff upon arrival to the emergency department. The DON confirmed the transfer form does not include a specific reason for transfer but more of a generic reason for a medical condition present. A policy on admission/transfer/discharge was requested. An Admission and Continued Stay Policy undated. included: - Long Term Continued Stay criteria includes continues to meet admission eligibility requirements; does not meet the limited criteria for notice of transfer or discharge from 42 CFR 483.15 which are: The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;, the health of individuals in the facility would otherwise be endangered; the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility.
F 625	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245501	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 10/30/2024

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BENEDICTINE LIVING COMMUNITY OF ST. PETE	**1907 KLEIN STREET ST PETER, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 625	Continued From Page 3

(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure 1 of 2 resident (R33) or legal representatives reviewed for hospitalizations had been informed of bed hold rights at the time of transfer/discharge to hospital.

Findings include:

R33's face sheet printed 10/30/24, indicated R33 and was transferred to the hospital on 9/19/24 returning to the facility 9/24/24, 10/13/24 returning to the facility 10/15/24, and 10/21/24 returning to the facility on 10/29/24. R33 had diagnoses of osteomyelitis (infection in the bone) of the left ankle and foot, acute respiratory failure with hypoxia (low oxygen level) and acute kidney failure.

R34's annual Minimum Data Set (MDS) dated 1/3/24, indicated R33 had intact cognition, is understood and understands.

A progress note 9/19/24 12:11 p.m., by licensed practical nurse (LPN)-E indicated R33 was sent to the emergency department with oxygen saturation in low 70's increasing to mid 80 range on 3 liters nasal cannula.

A progress note 9/24/24 7:16 p.m., by LPN-F indicated R33 returned to the facility at 1:30 p.m..

An electronic Bed Hold Policy Notification form dated 9/19/24, was present in the electronic medical record. The form did not include if bed hold was requested or denied or given to the patient and/or family member.

A progress note 10/13/24 at 4:58 p.m., by LPN-G indicated R33 was sent to the emergency department for oxygen saturation of 84% improving to 94% on 2 liters of nasal cannula.

An electronic Bed Hold Policy Notification form dated 10/15/24, was present in the electronic medical record. The form did not include if bed hold was requested or denied or given to the patient and/or family member.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245501	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 10/30/2024

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 625	Continued From Page 4

A progress note 10/15/24 at 2:10 p.m., by LPN-A indicated R33 returned to the facility.

A progress note dated 10/22/24 at 12:39 p.m., by registered nurse (RN)-C, included R33 was sent to the emergency department for evaluation due to difficulty breathing.

An electronic Bed Hold Policy Notification form dated 10/22/24, was present in the electronic medical record. The form did not include if bed hold was requested or denied or given to the patient and/or family member.

A 2nd Bed Hold Policy Notification Form (not part of electronic medical record) was received, dated 10/22/24, with resident/responsible party name and verbal acknowledgement given by family member of notification of bed hold policy. Instructions on the bottom of the form included 1 copy to resident at time of transfer, 1 copy to EMR and 1 copy to responsible party (if applicable).

On interview 10/29/24 at 12:54 p.m., LPN-B indicated she isn't sure what the process is for bed holds at this facility and would have to check with the unit manager.

On interview 10/29/24 at 1:02 p.m., LPN-A indicated a copy of the electronic bed hold notification is sent with the resident to the hospital upon transfer with the rest of the medical information that is shared. LPN-A added they typically don't give one to the resident or family if present but if they would ask for one, they will print it and give them a copy.

On interview 10/29/24 at 1:41 p.m., social services designee (SSD)-B indicated the nurses are responsible to go through the resident bed hold with the resident or family member and send with the resident to the hospital.

On interview on 10/29/24 at 1:58 p.m., registered nurse (RN)-A indicated the bed hold notification gets sent to the hospital with the resident. RN-A is unsure if a copy is actually being given to the resident or the hospital as it is generally in the packet of information that is sent with the resident. RN-A added the business office staff follow-up with a copy of the bed hold with family because it requires a signature.

On interview on 10/29/24 at 2:12 p.m., business office manager (BO)-G indicated social services staff (SS) is responsible to get the Bed Hold Policy Notification Form completed including signatures from the resident or the family if nursing doesn't get a signature or a verbal consent. SS generally follows up with the family the day after transfer and then scans the form into the electronic medical record. BO-G confirmed the signed Bed Hold Notification Form was not present for hospitalizations dated 9/19/24 and 10/13/24.

On interview 10/30/24 at 9:16 a.m., R33 indicated he doesn't remember being given a bed hold notice in writing when he had gone to the hospital over the past few months.

A policy was requested for Transfer and none was received.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF ST. PETE	**1907 KLEIN STREET ST PETER, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 625	Continued From Page 5

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 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF ST. PETER	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 10/28/24-10/30/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 018 SS=F	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.542(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the	E 018		12/16/24

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

Electronically Signed | 11/27/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF ST. PETER	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 018	Continued From page 1 following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.	E 018		

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 10/30/2024

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

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E 018	Continued From page 2 *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to include and identify in their emergency preparedness plan (EPP), a way to track staff or volunteers during an emergency. This had the potential to affect all 68 residents served by the facility, as well as staff, visitors and volunteers. Findings include: The facility's 5/2024 EPP was reviewed. The plan included a system/form to track clients during a facility evacuation. However, the plan lacked direction, policies, or procedures, to track locations of staff or volunteers during an emergency.	E 018	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. E018-The Emergency Preparedness policy was updated to address the tracking of on-duty staff and volunteers during a facility evacuation. On duty staff	

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E 018	Continued From page 3 When interviewed on 10/30/24 at 10:08 a.m., the social services designee (SSD), also identified as emergency preparedness coordinator was unable to locate or identify areas of the EPP that addressed tracking for on duty staff or volunteers. SSD indicated the need was identified at a September 2024, virtual table top drill, but has not been completed yet at this time.	E 018	will be assigned an evacuation location by the staffing coordinator. Staff will be tracked both through a manual process as well as our mobile timeclock application (Smartlinx Go). Once staff report to their assigned location, the on-duty staff will log into that location using our Smartlinx Go mobile application. Volunteers will also be assigned to emergency evacuation locations. We will then follow our Use of Volunteers Policy as outlined in our Emergency Operations Plan. A volunteer log will be kept at each location that will require volunteers to log in when at each location. The emergency relocation plan will be reviewed annually and updated as needed. Executive Director or designee to monitor for compliance.	
F 000	INITIAL COMMENTS On 10/28/24-10/30/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H55019823C (MN00101411). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are	F 000		

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F 000	Continued From page 4 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 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 1 of 2 residents (R65) reviewed who was observed to have medications at the bedside, had been appropriately assessed and deemed appropriate to self-administer medications. Findings include: R65's Admission Record printed 10/30/24, identified diagnoses including cerebral infarction (stroke), muscle weakness, chronic kidney disease, and vascular dementia. R65's admission Minimum Data Set (MDS) assessment dated 8/28/24, identified admission date of 8/22/24, moderately impaired cognition, impairment to both upper and lower extremities, dependent on staff for personal hygiene and transfers.	F 554	F-554- Eye drops removed from R65□s room on 10/30/24. Room sweep was completed and no other medications found without a Self-administration order. Resident unable to self-administer medications due to issues with loss of dexterity. Residents with self-administration administration orders are reviewed and an observation is completed that matches the self-administration order in Matrix. This is reviewed on a quarterly basis during each resident□s assessment period. The nursing staff was educated on Self-administration policy/procedure at the 11/20/24 Nursing Dept meeting. Director of nursing or designee will conduct random audits of resident□s	12/16/24

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F 554	Continued From page 5 R65's care plan dated 9/22/24, included goals of maintaining general orientation to person, place, and time, receiving appropriate assistance with business matters and decisions, and no adverse reactions to medications. R65's Physician's Order Report printed 10/30/24, identified an order for Artificial Tears 0.1%-0.3% (eye lubricant), one drop to both eyes twice per day. During observations on 10/28/24 at 2:33 p.m., and 7:09 p.m., 10/29/24 at 9:10 a.m., 1:05 p.m., and 3:43 p.m., an individual bottle of Systane eye drops (eye lubricant) was on top of R65's bedside table and within reach of R65, who was present in his bed. During interview on 10/29/24 at 3:45 p.m., registered nurse (RN)-D stated R65 did not have an order for self-administration of medications listed in his chart and should not have had Systane eye drops in his room without a physician's order for self-administration. During interview on 10/29/24 at 4:02 p.m., registered nurse (RN)-A, also known as nurse manager, stated she expected Systane eye drops to be in the medication cart, and they should not have been in R65's room without an assessment and order for self-administration of medications. RN-A further stated R65 did not have an assessment completed or a physician's order for self-administration of medications and the Systane eye drop should have been removed from the room. During interview on 10/30/24 at 12:24 p.m.,	F 554	rooms 3/week for 4 weeks and then 3/month for two months. Results will be reported through the Quality committee to determine further action if needed. Director of Nursing or designee to monitor for compliance.	

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F 554	Continued From page 6 director of nursing (DON) stated she would expect an assessment completed for self-administration of medication and a physician's order for self-administration prior to medications being left in R65's room. DON further stated an assessment should have been completed to ensure R65 was safe to have medications at bedside. Facility Self-Administration of Medications policy and procedure undated, included: Residents have the right to self-administer medications if the interdisciplinary team has determined it is clinically appropriate and safe. The nurses will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. Assessment is documented in the electronic medical record (EMR).	F 554		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by:	F 685		12/16/24

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F 685	Continued From page 7 Based on observation, interview, and document review the facility failed to provide treatment/services to maintain optimal visual abilities for 1 of 1 resident (R2) reviewed for vision. Findings include: R2's diagnoses included dizziness and giddiness, anemia, and type 2 diabetes. R2's admission minimum data set (MDS) dated 9/18/24, indicated adequate vision with glasses or other visual appliances and R2 has corrective lenses (contacts, glasses, or magnifying glass). R2's care plan dated 9/12/24, indicated R2 will be provided adaptive equipment/materials as needed for effective communication. On 10/28/24 at 11:31 a.m., during observation R2 was not wearing eyeglasses. On 10/29/24 at 9:14 a.m., during observation R2 was not wearing eyeglasses. On 10/28/24 at 11:32 a.m., during interview R2 stated eyeglasses need to be adjusted since they keep sliding down R2's nose. R2 stated staff were notified at the end of September and the eyeglasses have not been adjusted. On 10/29/24 at 9:15 a.m., during interview NA-A stated R2 does wear glasses and R2 asked for them to be adjusted. NA-A stated R2's concern was discussed with the unit manager "a while ago" and unsure if R2's glasses were ever adjusted.	F 685	F-685 An eye doctor appointment has been made for R2 on 12/10/24. No other like residents were identified. Upon admission and at quarterly care conferences, RN Case Manager□s will address the need to have hearing, dental, and vision appointments for residents. These services have been added to the formal care conference agenda to be reviewed quarterly at care conferences or as indicated. Case Managers□ educated on process to assure hearing, dental, and vision appointments are made as needed. Director of Nursing or designee will audit 2 care conference notes/week X 4 weeks and then weekly X one month. Results will be reported through the Quality committee to determine further action if needed. Director of Nursing or designee to monitor for compliance.	

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F 685	Continued From page 8 On 10/29/24 at 9:24 a.m., during interview licensed practical nurse (LPN)-B stated she is not sure if R2 wears glasses but did mention last week that R2 would like the eyeglasses fixed. R2 mentioned to LPN-B that R2 wanted to have eyeglasses adjusted and LPN-B told R2 she would inquire how to get the glasses adjusted. LPN-B stated eyeglasses need to be adjusted outside the facility. LPN-B stated she informed R2 that he needs an outside appointment, and the RN case managers helps with coordinating appointments. On 10/29/24 11:01 a.m., during interview registered nurse (RN)-A stated she was made aware that R2's eyeglasses need to be adjusted and stated, "I might have just forgot about it." RN-A stated she will help coordinate an appointment and transportation to have R2's eyeglasses adjusted. A facility policy addressing vision/eye glasses needs was requested but not received.	F 685		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or	F 757		12/16/24

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F 757	Continued From page 9 §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to identify diagnoses/indication for use of medications for 5 of 5 residents (R37, R48, R59, R67, R42) reviewed for unnecessary medications. Findings include: R37's admission MDS dated 10/1/24, indicated moderately impaired cognition, required substantial/maximal assistance with personal hygiene, and had behaviors including significantly disrupting the environment, wandering, verbal and physical behaviors. R37's care plan dated 9/26/24, indicated a potential to experience pain/discomfort but currently denies pain. An alteration in mood/behavior/symptoms related to new admission, dementia, anxiety, depression psychotic disturbance, aphasia, delirium, accusatory statements, pushing/pulling;throwing environmental objects at peers and staff, refusal of care. An additional plan of care indicated R37 receives psychotropic medications, antixolytic, antidepressant and antipsychotic medication.	F 757	F-757 R37, R48, R59, R67, R42 medications will be reviewed with indications added to the Matrix orders. All new admissions medication indications have been put in with their orders. Orders will be updated with the MDS schedule. All current residents will be audited for compliance and appropriate medication indications added to the Matrix orders. Licensed Nursing staff entering orders have been educated on medication indication compliance at the Nursing staff meeting on 11/20/24. Presence of proper medication indications will be reviewed daily at IDT meetings for all new orders. If no medication indication present, provider will be contacted to clarify need for medication and/or obtain an indication for the medication. All new medication orders will be audited X 4 weeks for medication indications.	

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F 757	Continued From page 10 R37's Physician Order Report dated 9/25/24 - 11/25/24, included the following medications but lacked indication for use or diagnosis: - acetaminophen [OTC] tablet, 500 mg twice a day - aspirin tablet delayed release 81 mg oral once a morning - atorvastatin 40 mg at bedtime - magnesium oxide 250 mg at bedtime - metoprolol tartrate 25 mg twice a day R37's Medication Administration Record (MAR) also lacked indication for use and administration of above medications. R48's admission MDS assessment dated 10/2/24, indicated severe cognitive impairment, required substantial/maximal assistance with dressing and toileting, partial/moderate assistance with bathing and personal hygiene, and diagnoses of renal failure, diabetes, arthritis, and dementia. R48's care plan dated 10/29/24, indicated psychotropic medications which placed R42 at risk for adverse reactions with interventions of attempting gradual dose reductions, non-pharmacological interventions, and monitoring for side effects. R48's Physician Order Report printed 10/30/24, included the following medications that lacked indication for use or diagnosis: -acetaminophen tablet, 500 mg four times per day -aspirin tablet, 81 mg daily -atorvastatin tablet, 20 mg daily -dapagliflozin propanediol tablet, 5 mg daily -donepezil tablet, 5 mg daily at bedtime -famotidine tablet, 40 mg daily at bedtime	F 757	Results will be reported through the Quality Committee to determine further action if needed. DON or designee will monitor for compliance	

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F 757	Continued From page 11 -ferrous sulfate tablet, 65 mg daily -finasteride tablet, 5 mg daily -Humalog KwikPen, 8 units three times per day -Lantus Insulin, 50 units at bedtime -meclizine tablet, 25 mg as needed -metformin tablet, 1000 mg twice per day -metoprolol tartrate tablet, 12.5 mg twice per day -Miralax, 17 gram daily -multivitamin tablet, daily R48's Medication Administration Record (MAR) also lacked indications for use and diagnoses for above medications. R59's quarterly MDS assessment dated 8/13/24, indicated no cognitive impairment, impairment of upper and lower extremities, use of wheelchair, substantial/maximal assistance with toileting, bathing, dressing, transfers, and diagnoses of dementia and Parkinson's disease. R59's care plan printed 10/30/24, indicated high risk medications placing R59 at risk for adverse reactions. Interventions included administering medications per physician order, observing for side effects of medications, and reporting indications of intolerance. R59's Physician Order Report printed 10/30/24, included the following medications that lacked indication for use or diagnosis: -acetaminophen tablet, 1000 mg three times per day -bisacodyl suppository, 10 mg as needed -carbidopa-levodopa tablet, 25-100 mg three times per day -ketoconazole 2% shampoo, one time per week -Miralax, 17 gram daily -morphine solution, 5 mg every four hours as	F 757		

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F 757	Continued From page 12 needed -Senna Plus tablet, 8.6-50 mg daily at bedtime R59's Medication Administration Record (MAR) also lacked indications for use and diagnoses for above medications. R67's quarterly Minimum Data Set (MDS) assessment dated 8/14/24, indicated moderately impaired cognition, use of wheelchair, partial/moderate assistance with bathing, toileting, dressing, and diagnoses of hypertension (high blood pressure), renal failure, and dementia. R67's care plan printed 10/30/24, indicated psychotropic medications which placed R67 at risk for adverse reactions. Interventions included administering medication per physician's orders, monitoring for antipsychotic side effects, attempting gradual dose reductions, and attempting non-pharmacological interventions. R67's Physician's Order Report printed 10/30/24, included the following medications that lacked indication for use or diagnosis: -acetaminophen tablet, 500 mg three times per day and 1000 mg at bedtime -amlodipine tablet, 2.5 mg daily -aspirin tablet, 81 mg daily -carvedilol tablet, 3.125 mg twice per day -Senna-S tablet, 8.6-50 mg daily R67's Medication Administration Record (MAR) also lacked indications for use and diagnoses for above medications. R42's quarterly Minimum Data Set (MDS) dated 8/3/24, indicated severe cognitive impairment, required substantial/maximal assistance with	F 757		

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F 757	Continued From page 13	F 757		

personal hygiene, and diagnoses of Alzheimer's disease and atrial fibrillation (heart arrhythmia).

R42's care plan dated 10/29/24, indicated high risk medications which place R42 at a high risk for adverse reactions: anticoagulant (blood thinner); administer anticoagulant as ordered by MD/NP (medical doctor/nurse practitioner)

R42's Physician Order Report dated 9/30/24-10/30/24, indicated warfarin (blood thinning medication) tablet; 2.5 mg (milligram), once an evening and lacked diagnosis or indication for use.

R42's Medication Administration Record (MAR) dated 10/1/24-10/30/24, indicated warfarin tablet 2.5 mg once an evening, and lacked diagnosis or indication for use.

On 10/30/24 at 10:05 a.m., director of nursing (DON) stated resident's medications were expected to have a indication or diagnosis on the MAR and provider orders to ensure staff knew the indication for the medication. The DON confirmed R42's MAR and physician orders lacked diagnosis or indication for the warfarin.

On 10/30/24 at 11:04 a.m., the consulting pharmacist (CP)-C stated the provider was responsible to attach a diagnosis to the medication order, and stated if a medication order did not have a diagnosis the facility should contact the provider. CP-C stated an indication for each medication was expected in the electronic medical record (EMR) for each medication order.

The facility Administering Medications policy

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F 757	Continued From page 14 dated 8/31/23, indicated To ensure safe administration of resident's medication as indicated and ordered by the provider. Policy: To administer resident medications in a safe and accurate manner that will ensure the 6 rights of patient indication for administration.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758		12/16/24

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 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF ST. PETER	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 758	Continued From page 15 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to identify diagnoses/indication for use of medications for 2 of 5 residents (R37, R59, R67) reviewed for unnecessary medications. Findings include: R37's admission MDS dated 10/1/24, indicated moderately impaired cognition, required substantial/maximal assistance with personal hygiene, and had behaviors including significantly disrupting the environment, wandering, verbal and physical behaviors. R37's care plan dated 9/26/24, indicated a potential to experience pain/discomfort but currently denies pain. An alteration in mood/behavior/symptoms related to new admission, dementia, anxiety, depression	F 758	F 758 - R37, R 59 Psychotropic medication indications have been added for the two mentioned residents. All new admissions medication indications have been put in with their orders. Orders will be updated with the MDS schedule. All current residents will be audited for compliance and appropriate medication indications added to the Matrix orders. Licensed Nursing staff entering orders have been educated on medication indication compliance at the Nursing staff meeting on 11/20/24. Presence of proper medication indications will be reviewed daily at IDT meetings for all new orders. If no medication indication present, provider will be contacted to	

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F 758	Continued From page 16 psychotic disturbance, aphasia, delirium, accusatory statements, pushing/pulling;throwing environmental objects at peers and staff, refusal of care. An additional plan of care indicated R37 receives psychotropic medications, antixolytic, antidepressant and antipsychotic medication. R37's Physician Order Report dated 9/25/24 - 11/25/24, included the following psychotropic medications but lacked indication for use or diagnosis except quetiapine: - buspirone 5 mg tablet twice a day - quetiapine 50 mg once a morning for delusional disorder R37's Medication Administration Record (MAR) also lacked indication for use and administration of above medications R59's quarterly MDS assessment dated 8/13/24, indicated no cognitive impairment, impairment of upper and lower extremities, use of wheelchair, substantial/maximal assistance with toileting, bathing, dressing, transfers, and diagnoses of dementia and Parkinson's disease. R59's care plan printed 10/30/24, indicated high risk medications placing R59 at risk for adverse reactions. Interventions included administering medications per physician order, observing for side effects of medications, and reporting indications of intolerance. R59's Physician Order Report printed 10/30/24, included the following medications that lacked indication for use or diagnosis: -sertraline tablet, 125 mg daily at bedtime R59's Medication Administration Record (MAR) also lacked indications for use and diagnoses for	F 758	clarify need for medication and/or obtain an indication for the medication. All new medication orders will be audited X 4 weeks for medication indications. Results will be reported through the Quality Committee to determine further action if needed. DON or designee will monitor for compliance	

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F 758	Continued From page 17 above medications. R67's quarterly Minimum Data Set (MDS) assessment dated 8/14/24, indicated moderately impaired cognition, use of wheelchair, partial/moderate assistance with bathing, toileting, dressing, and diagnoses of hypertension (high blood pressure), renal failure, and dementia. R67's care plan printed 10/30/24, indicated psychotropic medications which placed R67 at risk for adverse reactions. Interventions included administering medication per physician's orders, monitoring for antipsychotic side effects, attempting gradual dose reductions, and attempting non-pharmacological interventions. R67's Physician's Order Report printed 10/30/24, included the following medications that lacked indication for use or diagnosis: -buspirone tablet, 5 mg twice per day -Lexapro tablet, 20 mg daily R67's Medication Administration Record (MAR) also lacked indications for use and diagnoses for above medications. On 10/30/24 at 10:05 a.m., director of nursing (DON) stated resident's medications were expected to have a indication or diagnosis on the MAR and provider orders to ensure staff knew the indication for the medication. On 10/30/24 at 11:04 a.m., the consulting pharmacist (CP)-C stated the provider was responsible to attach a diagnosis to the medication order, and stated if a medication order did not have a diagnosis the facility should	F 758		

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F 758	Continued From page 18 contact the provider. CP-C stated an indication for each medication was expected in the electronic medical record (EMR) for each medication order. The facility Administering Medications policy dated 8/31/23, indicated To ensure safe administration of resident's medication as indicated and ordered by the provider. Policy: To administer resident medications in a safe and accurate manner that will ensure the 6 rights of patient indication for administration.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free of significant medication errors for 1 of 8 residents (R15) reviewed for medication administration. Finding include: R15's Face Sheet printed 10/30/24, indicated diagnoses of unspecified dementia, muscle weakness, anxiety disorder, and essential primary hypertension (high blood pressure). R15's quarterly Minimum Data Set (MDS) dated 8/14/24, indicated severely impaired cognition, use of a wheelchair, and substantial assistance required for dressing, bathing, and hygiene.	F 760	F-760 R15□s medications were reviewed and indications were added as to what could be crushed. All residents needing crushed medications will be reviewed to make sure there is an order to crush and that the appropriate form of medication ordered that is able to be crushed. If medication is unable to be crushed, clear instructions will be added to the order stating such. TMA was educated on long acting or extended-release appropriate medication administration procedure. Staff Development RN will follow up with medication administration competencies	12/16/24

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F 760	Continued From page 19 R15's care plan printed 10/30/24, indicated self-care deficit related to dementia with goal of maintaining current abilities and safety. R15's physician's orders dated 10/29/24, indicated an order for metoprolol succinate tablet extended release 25 mg tablet (blood pressure medication) daily for high blood pressure. During observation on 10/29/24 at 8:02 a.m., trained medication aide (TMA)-A prepared medications for administration to R15. TMA-A crushed acetaminophen 500 mg tablets, escitalopram 15 mg tablet, magnesium 400 mg tablet, senna-docusate 50-8.6 mg tablet, and metoprolol succinate extended release 325mg tablet for ease of swallowing for R15. During interview on 10/29/24 at 8:05 a.m., prior to administration of medication to R15, TMA-A verified she had been crushing R15's metoprolol succinate extended release tablet for quite some time due to R15's difficulty swallowing multiple pills and intended to administer metoprolol succinate tablet crushed. TMA-A further verified there was no order to crush metoprolol succinate extended release tablet. TMA-A verified with registered nurse (RN)-A that metoprolol succinate extended release tablet could not be crushed and disposed of crushed medication mixture. During interview on 10/29/24 at 8:54 a.m., RN-A stated there should be an order for crushing medications. RN-A stated sometimes staff will start crushing medications without an order due to residents not being able to take them whole. RN-A further stated R15 did not have an order to crush medications and metoprolol succinate extended release tablets should not have been	F 760	for this TMA. Education was provided to all nursing staff at the 11/2024 nursing meeting. DON or designee to audit 3 medication passes per week for 3 weeks and then 3 per month to ensure proper crushing of medications. Results will be reported through the Quality Committee to determine further action if needed. Director of Nursing or designee to monitor for compliance.	

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F 760	Continued From page 20 crushed due to medication being extended release. During interview on 10/30/24 at 10:34 a.m., director of nursing (DON) stated metoprolol succinate extended release tablet should not have been crushed and would expect an order to crush medications for R15 if her medications were being crushed. During interview on 10/30/24 at 11:04 a.m., consulting pharmacist (CP)-A stated metoprolol succinate extended release was not expected crushed, and stated crushing of the extended release tablet interferes with the disbursement of the medication and disrupts the medication's intended use. The facility Administering Medications policy reviewed 8/31/23, included the following: Medications are administered in accordance with the orders.	F 760		
F 880 SS=D	. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		12/16/24

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F 880	Continued From page 21 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 22 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was completed for 2 of 8 residents (R23 and R127) observed for medication administration. Finding include: R23's admission Minimum Data Set (MDS) dated 8/22/24, indicated moderately impaired cognition, required supervision with personal hygiene. R23's care plan dated 9/4/24, indicated staff to apply gloves and gowns prior to facility-identified high-contact care activities, discard PPE in designated location following activities, and sanitize hands after PPE removal. R127's face sheet dated 10/30/24, indicated	F 880	F-880 LPN D had a hand hygiene competency performed prior to start of agency contract. Director of Nursing did medication administration handwashing re-education to the LPN on 10/29/24. LPN reported she was nervous and was aware she made errors during the survey. Proper handwashing is part of all staff□s on-going education, this includes medication administration handwashing. All agency staff will review our medication administration handwashing procedure and be audited randomly by our Staff Development RN. Medication administration handwashing education was provided to all nursing staff at the 11/2024 nursing meeting.	

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F 880	Continued From page 23 R127 was admitted 10/24/24, with diagnoses including left femur (hip) fracture and fracture of shoulder. On 10/28/24 at 7:03 p.m., licensed practical nurse (LPN)-D entered R23's room with eye drops, lidocaine (prevent and to treat pain) bottle, medication cup with apple sauce, and medication cup with a pill. LPN-D placed gloves on both hands and administered R23's eye drops to both eyes, used the lidocaine bottle and rolled on the lidocaine on R23's right shoulder, then placed a pill on the spoon and used apple sauce and administered R23's pill. LPN-D exited the room and walked to the medication storage area, removed gloves, used keys to unlock the medication storage drawers, and returned the eye drops and lidocaine to the medication drawer. LPN-D was further observed to place the medication cup with applesauce and spoon uncovered in the medication drawer. LPN-D stated the applesauce was placed in the drawer to use later for R23's administration of Tylenol. LPN-D was not observed to complete hand hygiene or disinfect hands during or after R23's medication administration. At 7:12 p.m., LPN-D entered the other side of Eagle wing medication area and was observed to prepare R127's medications, and then entered R127's room and failed to complete hand hygiene prior to entering R127's room. LPN-D was observed to hand R127 a medication cup with pills. R127 asked for more water in her water insulated uncovered mug and LPN-D with bare hands grabbed the mug and exited R127's room, entered the dining area and used the water dispenser to place water in the insulated mug, LPN-D reentered R127's room used bare hands and touched the top of the lid to push down the lid and attached the lid to the mug.	F 880	DON or designee to complete random medication administration handwashing audits 3/week X 4 weeks and then 1/week X 4 weeks. Results are reported through Quality Committee to determine further action if needed.	

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F 880	Continued From page 24	F 880		

LPN-D exited the room and walked to the medication storage cabinets and used a sink and washed her hands. LPN-D did not sanitize her hands during the entire medication pass.

On 10/28/2424 at 7:27 p.m., LPN-D confirmed hand hygiene was not completed during the medication pass with R23 and R127. LPN-C stated it was not her normal process to perform hand hygiene when gloves were used. LPN-A confirmed hand hygiene was expected prior to R127's lid placed on the water mug.

On 10/29/24 at 11:58 a.m., registered nurse (RN)-B, known as the nurse manger, stated staff were expected to complete hand hygiene after glove removed and prior to entering or exiting resident's room, and prior to the next medication administration.

On 10/29/24 at 2:39 p.m., RN-A, known as infection preventionist nurse, and director of nursing (DON) stated staff were expected to perform hand hygiene before and after medication pass, between resident contact, and entering in and out of resident rooms.

The facility Hand Hygiene policy dated 9/23, indicated: Infection Prevention begins with the basic hand hygiene. By following proper hand hygiene practices, associates will reduce the spread of potentially deadly germs, as well as reduce the risk of healthcare provider colonization caused by germs acquired from the residents. Times to Perform Hand Hygiene are, but not limited to: Before and after direct resident contact.

The facility Administering Medications dated

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F 880	Continued From page 25 8/31/23, indicated: Staff follows established infection control procedures for the administration or medications.	F 880		

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	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**10/30/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/30/2024. At the time of this survey, Benedictine Living Community, St Peter 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 | 11/27/2024

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

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BENEDICTINE LIVING COMMUNITY OF ST. PETER	**1907 KLEIN STREET ST PETER, MN 56082**

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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. Constructed in 2006 at two different times. The original building is a one story building with no basement of Type V(111) construction. The addition constructed in 2006, with a link to the hospital is a one story building with no basement of Type V(111) construction. The building is fully fire sprinkler protected. The nursing home is separated from a hospital and a senior housing facility by 2-hour fire wall assemblies, with opening protective's consisting of labeled, self-closing, positive latching, 90-minute fire rated	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 _____	**10/30/2024**

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K 000	Continued From page 2 door assemblies. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility also has automatic smoke detection in all sleeping rooms. The facility has a capacity of 79 beds and had a census of 70 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)	K 321		11/26/24

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K 321	Continued From page 3 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain Hazardous Areas-Soiled Linen Rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1 and 19.3.5.9. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 10/30/2024 at 10:15 AM, it was revealed by observation that the door on the Soiled Linen Room, E518, would not positively latch when the door closed. An interview with the Maintenance Director verified this deficient finding at the time of discovery	K 321	E-518 Door closure has been adjusted to allow for the door to properly latch. Door closures have been entered into the TELs system so that the maintenance staff will regularly monitor door closures on a monthly basis. Environmental Services Director or designee will monitor for compliance	
K 354 SS=C	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion	K 354		11/26/24

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	245501	A. BUILDING **02 - NEW BUILDING** B. WING _____	**10/30/2024**

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K 354	Continued From page 4 of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement a sprinkler system fire watch per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1, 9.7.5, 15.5.2 and NFPA 25. This deficient findings could have a isolated impact on the residents within the facility. Findings include: On 10/30/2024 at 10:00AM, it was revealed by observation and staff interview that the fire sprinkler system was taken out of service on October 25, 2024 at 10:00AM and remained out of service for 72 hours. There was no notification from the facility given to the St Peter Fire Department or the Minnesota State Fire Marshal that the facility was in a fire watch condition. An interview with the Adminstrator verified this deficient finding at the time of discovery.	K 354	K-0354 St Peter Fire Department was aware the system was out of service as they responded to the fire call on the morning of 10/26/24. The Environmental Services Director or Executive Director will be responsible for notifying the State Fire Marshall when the system is down for more than 10 hours in a 24-hour period and the facility is in a fire watch condition. Compliance will be monitored through our monthly safety meetings.	