DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 17, 2024

Administrator
St. Benedicts Care Center
1810 Minnesota Boulevard Southeast
Saint Cloud, MN 56304

RE: CCN: 245350
Cycle Start Date: July 25, 2024

Dear Administrator:

On August 27, 2024, the Minnesota Department of Health, 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Electronically delivered
August 7, 2024

Administrator
St. Benedicts Care Center
1810 Minnesota Boulevard Southeast
Saint Cloud, MN 56304

RE: CCN: 245350
Cycle Start Date: July 25, 2024

Dear Administrator:

On August 6, 2024, we informed you that we may impose enforcement remedies.

On August 1, 2024, the Minnesota Departments of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency not corrected from the July 25, 2024 survey exit, is: F777

In addition, at the time of the August 1, 2024 survey exit, we identified the following deficiencies: F578, F732, F880, and F883

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 25, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 25, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 25, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 25, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St Benedicts Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 25, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 25, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42

CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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://forms.web.health.state.mn.us/form/NHDisputeResolution

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:

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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING _____ B. WING _____	08/01/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 7/29/24 through 8/1/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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 7/29/24 through 8/1/24, a standard recertification survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the 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 substantial compliance with the regulations has been attained.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to	F 578		8/20/24

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

Electronically Signed | 08/16/2024

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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F 578	Continued From page 1 formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility	F 578	R110's advanced directive was initially	

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F 578	Continued From page 2 failed to ensure the correct advanced directives were documented and stored in the resident's paper chart for 1 of 1 resident (R110) reviewed for advanced directives. Findings include: R110's face sheet dated 7/30/2024, indicated R110's advance directive wishes were Do Not Resuscitate (DNR). R110's current order summary report dated 8/2/24, indicated R110 was a DNR. On 7/29/24 at approximately 2:25 p.m., R110's paper chart included an Advanced Directive Consent (ADC), however it was for Full code, and had another residents name on the form, not R110's. On 7/29/24 at 2:30 p.m., registered nurse (RN)-A stated they would go to the paper chart to verify the residents code status. On 7/29/24 at 2:30 p.m., licensed practical nurse (LPN)-A stated they would go to the paper chart to verify the residents code status. LPN-A retrieved R110's paper chart and stated R110 was a full code. LPN was directed to verify the resident's name on the ADC and LPN-A stated the person was not the same. It was not R110's ADC. On 7/29/24 at 2:39 p.m., the unit manager RN-B stated they expected staff to look at the paper chart for code statuses and if for some reason the ADC was not there, they expected them to refer to point click care (PCC) the resident's electronic health record. RN-B retrieved R110's	F 578	placed into the incorrect chart. Upon finding this discrepancy on 7/29/2024, a whole house chart audit was completed to ensure all advanced directives were in the correct chart. No other discrepancies were noted throughout the building. To ensure there will be no recurrence, advanced directives will not be taken out of the chart for the primary care provider to sign. Audits will take place bi-weekly on 10% of charts for the next 3 weeks. Audits will then decrease to 10% of charts weekly for an additional 2 weeks. The facility will be in compliance on 8/20/2024.	

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F 578	Continued From page 3 paper chart, and identified the form for another resident was present in R110's chart, not R110's. On 8/1/24 at 10:28 a.m., the director of nursing (DON) (O)-A stated if their staff needed to verify a code status of a resident they should go to the paper chart. O-A stated their policy was, upon admission to review the residents advance directive wishes, have the physician sign off on the order, put it in the paper chart and update orders and care plans accordingly. The Advance Directive Facility Policy last revised September of 2022, indicated if the resident or the residents representative has executed one or more advance directives, or executes one upon admission, copies of these documents are obtained and maintained in the same section of the residents medical record and are readily retrievable by any facility staff.	F 578		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F 732		8/20/24

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F 732	Continued From page 4 §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility failed to accurately post facility staffing hours with the potential to affect all residents and visitors. Findings include: On 7/30/24 at 9:00 a.m., the staff posting was observed in a public area next to a main set of elevators. Review of daily staff posting and schedules showed a discrepancy between hours worked and hours scheduled. The staff posting did not include all hours scheduled and did not have a category for registered nursing (RN).	F 732	Nursing hours to be posted daily will consist of the following information: (i)Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census	

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F 732	Continued From page 5 On 7/30/24 at 12:48 p.m., director of nursing (DON) stated the daily staff posting was completed by herself or a health information specialist during the week and by another staff member over the weekend. The DON stated the schedule would be updated and reprinted if a call in or change occurred. The DON confirmed the daily staff posting did not reflect the staff schedule. The DON confirmed the daily staff posting listed all licensed nursing staff as licensed practical nurses (LPN) and did not differentiate between LPN and RN hours. The staff posting did not indicate an RN scheduled in the building at any time. The DON stated it would be important for the staff posting to accurately represent the staff in the building so residents and visitors would be aware of staffing. During interview on 7/31/24 at 2:20 p.m., the DON stated she had spoken with the software company that the staff posting was printed from and there had been an error in report. The daily staff posting had been incorrect since the software had been utilized. The facility started to use the software on March 22, 2024. Facility policy Posting Direct Care Daily Staffing Numbers dated August 2022, included the number of licenses nurses and number of unlicensed nursing personnel responsible for direct care will be posted within two hours of the beginning of each shift. This posting would include the type (RN, LPN, CAN) and category (licensed or non-licensed) of nursing staff working.	F 732	The facility was made aware of incorrect nursing hours posted and identified the issue of how agency staff were being entered into the staffing system. After identifying the problem, schedules were re-entered into the system to give accurate nursing hours. Accurate Nursing hours were then posted in a well visible area. Audits will be completed three times a week for a duration of 3 weeks to ensure correct nursing hours are posted. The facility will be in compliance on 8/20/2024.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		8/23/24

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F 880	Continued From page 6 §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. §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 §483.70(e) 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:	F 880		

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ST BENEDICTS CARE CENTER	1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304

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F 880	Continued From page 7 (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 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 record review facility failed to follow infection control protocol for 1 of 1 residents (R21) on contact precautions. Findings include: On 7/29/24 at 2:10 p.m., a sign was observed posted on R21's door that indicated the resident was on contact precautions. The sign had two stop signs, one in each of the upper corners of	F 880	R21 was on contact precautions. H-A entered the room with only gloves on. Immediate education was given to H-A on contact precautions and anytime entering R21’s room or any other patient on contact precautions, gown and gloves will be worn no matter what task is being completed. H-A verbalized understanding. Education was also given to the whole department regarding contact precautions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING _____ B. WING _____	08/01/2024

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

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F 880	Continued From page 8 the sign, and bold upper-case wording "Contact precautions everyone must." The sign included instructions to wash hands before entering and when leaving the room, put on gown and gloves before entering the room and remove before exiting the room. Gloves and gowns were in a hanging yellow container on the door next to the sign. A progress noted dated 7/29/24 included the resident was on contact precautions until further notice or update. On 7/31/24 at 8:00 a.m., housekeeper (H)-A was observed in R21's room adjusting a blanket on R21's bed. H-A was wearing only gloves, no gown. H-A swept the floor and exited the room, removing gloves upon exit. On 7/31/24 at 8:02 a.m., H-A stated R21 was only on precautions when she was having personal cares completed. H-A stated since she was only adjusting the blanket and cleaning, she did not have to wear a gown. H-A did confirm R21 had a sign on her door indicating the resident was on contact precautions and did confirm the sign included everyone should wear a gown and gloves. During interview on 7/31/24 at 8:11 a.m., unit manager registered nurse (RN)-A confirmed anyone who has direct contact with the resident or items in the resident's room, such as bedding, should wear a gown and gloves when a resident was on contact precautions. RN-A confirmed gown and gloves should be worn when adjusting a blanket or when providing housekeeping. RN-A confirmed R21 was currently on contact precautions for an unknown rash.	F 880	To ensure there is no recurrence, all house staff education will take place via PowerPoint reviewing contact precautions and the proper way to DON PPE. Leaders will review what PPE is required (gown, gloves and utilizing hand sanitizer for hand hygiene) and the signage placed on the resident doors, so all staff are knowledgeable. Bi-weekly audits will take place on contact precautions for 3 weeks and then once a week audits for 2 weeks. The facility will be in compliance on 8/23/2024.	

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	245350	A. BUILDING _____ B. WING _____	08/01/2024

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F 880	Continued From page 9 During interview on 7/31/24 at 10:05 a.m., director of nursing (DON) stated she expected staff to follow contact precautions signage posted on the door. A gown and gloves were required for contact precautions. DON confirmed a gown and gloves should be worn when providing housekeeping services and when adjusting blankets on residents. Facility policy Isolation - Categories of Transmission-Based Precautions dated September 2022, included contact precautions were implemented for residents with known or suspected infections that could be transmitted with direct contact. Signage would be placed on the resident's door with instructions on the type of precautions. Staff and visitors were to wear a disposable gown when entering the room.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes	F 883		8/20/24

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F 883	Continued From page 10 documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 883	All patients on admission who are eligible	

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	245350	A. BUILDING _____ B. WING _____	08/01/2024

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F 883	Continued From page 11 facility failed to ensure 4 of 5 residents (R21, R25, R28, R53) were offered and/or provided the pneumococcal vaccine series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 65 years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 65 years old. R21's significant change minimum data set (MDS) dated 6/5/24, indicated hypertension (high blood pressure), peripheral vascular disease (poor blood vessel flow) malnutrition (poor nutrition), and respiratory failure (difficulty breathing). R21 had not received any pneumococcal immunization, and MDS had indicated it had been offered and declined. R25's quarterly minimum data set (MDS) dated 7/23/24, indicated heart failure (failing heart), hypertension (high blood pressure), and age-related physical debility (reduced physical ability). R25 had not received any pneumococcal immunization, and MDS had indicated it had been offered and declined.	F 883	for PCV20 will be offered the immunization in collaboration with the physician. All patients on admission will be offered an influenza immunization unless the immunization is medically contraindicated, or the resident has already been immunized during this time period Facility will complete an audit of all current patients who can receive the PCV20 and collaborate with the physician to obtain written orders. Patients wanting to receive the PCV20 will sign their consent to receive the immunization. Vaccine Information Statement (VIS) will be given to all patients, or representative, who consent to the PCV20. Education will be documented under the immunization tab of Point Click Care (PCC). Patients wanting to receive the Influenza immunization will sign their consent to receive the immunization. Vaccine Information Statement (VIS) will be given to all patients, or representative, who consent to Influenza. Education will be documented under the immunization tab of Point Click Care (PCC). If a patient declines immunization upon admission and has an admission longer than 30 days; PCV20 and influenza (during season) will be offered again, and then 30 days thereafter. Declination of immunization will be placed in the paper chart each time, a new entry for refusal will be listed under the immunization tab of PCC. All patients will be added to a spreadsheet	

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F 883	Continued From page 12 R28's quarterly minimum data set (MDS) dated 7/18/24, indicated coronary artery disease (heart and artery disease), cerebrovascular accident (stroke), Parkinson's disease (involuntary movement), and malnutrition (poor nutrition). R28 had not received any pneumococcal immunization, and MDS had indicated it had been offered and declined. R53's quarterly minimum data set (MDS) dated 7/2/24, indicated age-related physical debility (reduced physical ability), malnutrition (poor nutrition), and dementia (Poor memory). R53 had not received any pneumococcal immunization, and MDS had indicated it had been offered and declined. R21, R25, R28, and R53's Immunization record indicated that no pneumococcal immunization had been administered, offered, or refused. R21 and R25's "Pneumococcal Vaccination Consent Declination" indicated refusal and resident dated 7/31/24. Consent Form offered residents and representatives the PPSV23, PCV13, PCV15, and PCV20 immunizations. R28's "Pneumococcal Vaccination Consent Declination" indicated yes to receiving a pneumococcal vaccination and was dated 7/31/24. Consent Form offered residents and representatives the PPSV23, PCV13, PCV15, and PCV20 immunizations. R53's "Pneumococcal Vaccination Consent Declination" indicated yes to receiving a pneumococcal vaccination and was dated 11/9/23. Consent Form offered residents and representatives the PPSV23, PCV13, PCV15,	F 883	to track their length of stay and when to re-offer the immunization. Immunization audits will be completed bi-weekly for 2 months based on the spreadsheet utilized on all new admissions, and any patient that would initially decline. The spreadsheet contains patient name, pneumococcal status, influenza status, rational if eligible of not. On the spreadsheet, there will be highlighted columns on admission if they are due for an immunization. This section will stay highlighted until the immunization is complete, or declination is in the paper chart. R21, R25, R28, and R53 were not offered the PCV20 vaccinations upon admission. R21 was offered and refused- declination was placed into chart R28 was offered and consented- consent placed into chart and received the vaccination. R25, R53 were then offered both immunizations and consents and/or declinations were placed in paper chart. The facility will be in compliance on 8/20/2024. Director of Nursing to complete education with Nurse Managers with a power point on who will be offered, and how to properly document.	

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F 883	Continued From page 13 and PCV20 immunizations. During an interview on 7/31/24 at 3:57 p.m., director of nursing (DON) stated she is the infection preventionist and the records for R21, R25, R28, and R53 failed to indicate the PCV20 vaccinations had been administered. The DON stated the declinations were just preformed for those residents that day. During an interview on 8/1/24 at 9:16 a.m., DON stated a recent audit had been done for all facility residents, and that it had not been done until 7/31/24. DON stated the vaccinations should have been reviewed earlier and offered. The DON stated it was an issue and was reviewing the facility policy. A facility policy titled "Pneumococcal Vaccine", was provided. Policy indicated: Residents will be offered the pneumococcal vaccination and administered, according to CDC recommendations. Facility policy failed to indicate the administration of the PVC15 and PVC20.	F 883		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 7, 2024

Administrator
St. Benedicts Care Center
1810 Minnesota Boulevard Southeast
Saint Cloud, MN 56304

Re: Event ID: ZIQO11

Dear Administrator:

The above facility survey was completed on August 1, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00774	A. BUILDING: _____ B. WING _____	08/01/2024

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On (7/29/24 through 8/1/24), a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. The Minnesota Department of Health is	2 000		

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	00774	A. BUILDING: _____ B. WING _____	08/01/2024

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2 000	Continued From page 1 documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		

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	245350	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/31/2024**

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ST BENEDICTS CARE CENTER	**1810 MINNESOTA BOULEVARD SOUTHEAST** **SAINT CLOUD, MN 56304**

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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 07/31/2024. At the time of this survey, Saint Benedicts Senior Community was found 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. St. Benedicts Senior Community is a 5-story building with a full basement and an Elevator Equipment Penthouse. The building was constructed at 2 different times. The original building was constructed in 1978 and was determined to be of Type 1(332) construction. In 1997, a 2-story addition was added to the northeast that was determined to be of Type II (111) construction. Also in 2008, there was a 2 story, with no basement determined to be a Type II (III) Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors that is monitored for automatic fire department notification.	K 000		

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

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

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K 000	Continued From page 1 The facility has a capacity of 97 beds and had a census of 61 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		