

Office of Health Facility Complaints Investigative Report PUBLIC

Facility Name: St. Benedicts Senio	or Community		Report Number: H5350061	Date of Visit: July 6 and 7, 2017		
Facility Address: 1810 Minnesota Boulevard SE			Time of Visit: 3:00 p.m. to 7:00 p.m. 10:30 a.m. to 3:30 p.m.	Date Concluded: December 29, 2017		
Facility City: St Cloud	•			Title: al Investigator		
State: Minnesota	ZIP: 56304	County: Sherburne				

Nursing Home

Allegation(s):

It is alleged that a resident was abused when the resident was found to be restrained to his/ her wheelchair with a gait belt.

- Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, abuse occurred when the alleged perpetrator (AP) physically restrained the resident in the wheelchair and/or recliner several times within a three week period to prevent the resident from standing up.

The resident had severe cognitive impairment, walked with two staff, and was assessed as not safe to walk without staff as s/he had fallen in the past when attempting to walk independently.

The night shift staff observed the resident sitting in the wheelchair with a gait belt around her/his waist. The belt was tucked beneath the wheelchair handles to prevent the resident from self transferring. The resident was attempting to stand from the wheelchair, but was not able to as a gait belt was restraining the resident in the wheelchair. The facility investigation indicated staff saw the resident sitting in the wheelchair near the nurses desk with a blanket over their lap. The resident attempted to stand up out of the wheelchair and the blanket fell off the resident. Staff noted the gait belt around the residents waist restraining the resident in the wheelchair. The house charge nurse was notified and directed the AP to remove the gait belt. The facility indicated during the investigation it was determined the AP had restrained the resident on three

Community different occasions in the prior three weeks. The AP used a gait belt, a bed sheet tied around the residents waist and secured on the back of the wheelchair, and also raised the foot rest on a recliner and put a foot stool under the foot rest so the resident was unable to get out of the recliner. The resident was unable to be interviewed due to his/her cognitive status. When interviewed, the AP stated s/he used a gait belt to remind the resident to stay sitting in the wheelchair so the resident didn't attempt to self transfer and fall. The AP stated s/he had used the gait belt other times in the past three weeks to restrain the resident in the wheelchair and it worked well to keep the resident in the wheelchair. The AP stated s/he was aware residents could not be restrained. During staff interviews, three staff members were aware the AP had restrained the resident in the wheelchair and/or the recliner in the past three weeks. None of the three staff reported to the facility the AP restrained the resident although staff stated they were aware the facility policy indicated restraints could not be used. The facility re-educated all staff regarding restraints and reporting abuse immediately. The AP was suspended during the course of the investigation, and terminated from employment at the completion of the facility investigation. Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557) Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557): ☐ Neglect ☐ Financial Exploitation Substantiated
 Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information: Mitigating Factors: The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the \(\subseteq \) Individual(s) and/or \(\subseteq \) Facility is responsible for the Abuse ☐ Neglect ☐ Financial Exploitation. This determination was based on the following: The AP, and all staff at the facility, had been educated on the facility policy regarding restraints and abuse upon hire and annually. The facility failed to ensure the AP, and other staff at the facility, followed the facility policy. The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C. Compliance:

Report Number: H5350061

Facility Name: St. Benedicts Senior

Facility Name: St. Benedicts Senior Report Number: H5350061 Community Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met. Deficiencies are issued on form 2567: X Yes □ No (The 2567 will be available on the MDH website.) State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met. State licensing orders were issued: x Yes □ No (State licensing orders will be available on the MDH website.) State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met. State licensing orders were issued: X Yes ☐ No (State licensing orders will be available on the MDH website.) State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met The requirements under State Statues for Chapters 144 &144A were not met. State licensing orders were issued: X Yes (State licensing orders will be available on the MDH website.) **Compliance Notes: Definitions:** Minnesota Statutes, section 626.5572, subdivision 2 - Abuse "Abuse" means: (b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion,

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory,

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

humiliating, harassing, or threatening;

Facility Name: St. Benedicts Senior

Community

Report Number: H5350061

including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- ▼ Medical Records
- Care Guide
- ▼ Medication Administration Records
- Nurses Notes
- **X** Assessments
- Physician Orders
- ▼ Treatment Sheets
- Physician Progress Notes
- X Care Plan Records
- ▼ Meal Intake Records
- Social Service Notes
- Skin Assessments
- **X** Facility Incident Reports
- **X** Activities Reports
- Laboratory and X-ray Reports
- Therapy and/or Ancillary Services Records
- ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

Other, specify:

Facility Name: St. Benedicts Senior

Community

Ado	litional facility records:								
X	Resident/Family Council Minutes								
X	Staff Time Sheets, Schedules, etc.								
X	Facility Internal Investigation Reports								
X	Call Light Audits								
X	Personnel Records/Background Check, etc.								
X	Facility In-service Records								
X	Facility Policies and Procedures								
	nber of additional resident(s) reviewed: Six								
	re residents selected based on the allegation(s)? Yes No N/A cify:								
Wer	re resident(s) identified in the allegation(s) present in the facility at the time of the investigation?								
\[\) \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\] \[\]	′es ○ No ○ N/A								
Spe	cify:								
Inte	rviews: The following interviews were conducted during the investigation:								
Inte	rview with reporter(s) Yes No N/A								
Spe	cify:								
If ur	nable to contact reporter, attempts were made on:								
Dat	e: Time: Date: Time: Date: Time:								
	rview with family: Yes No N/A Specify:								
	you interview the resident(s) identified in allegation:								
	'es ○ No ○ N/A Specify: Cognitively impaired								
	you interview additional residents? Yes No								
	al number of resident interviews: Three								
	rview with staff: Yes No N/A Specify:								
Ten	nessen Warnings								
Ten	nessen Warning given as required: Yes No								
Tota	al number of staff interviews: 16								
Phv	sician Interviewed: O Yes O No								

Report Number: H5350061

No

Phy	rsician Assistant Interviewe	d: OYes •	No		
	erview with Alleged Perpet	rator(s): • Yes	○ No ○ N/A	Specify:	11. 14.
	empts to contact:	_		_	_
Dat	te: Time:	Date:	Time:	Date:	Time:
lf u	nable to contact was subpo	pena issued: () Ye	es, date subpoena v	was issued	. O No
We	re contacts made with any	of the following:			
	Emergency Personnel	Police Officers	☐ Medical Exam	iner 🗌 Other: S	Specify
Ob ×	servations were conducte Personal Care	d related to:			
X	Nursing Services				
X	Call Light				
X	Infection Control			•	
X	Use of Equipment				
X	Medication Pass				
X	Cleanliness				
X	Dignity/Privacy Issues				
X	Safety Issues				
X	Restorative Care				
X	Transfers				
X	Facility Tour				
X	Injury				
X	Other: Restraint use				
Wa	s any involved equipment s equipment being operate re photographs taken:	ed in safe manner:	○ No○ N/○ Yes○ NoSpecify:	N/A	
cc:					
He	alth Regulation Division - I	icensing & Certific	cation		
Mi	nnesota Board of Examine	rs for Nursing Hor	ne Administrators	,	
Mi	nnesota Board of Nursing				

Report Number: H5350061

Facility Name: St. Benedicts Senior

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The Office of Ombudsman for Long-Term Care
St Cloud Police Department
St Cloud City Attorney
Sherburne County Attorney

PRINTED: 12/31/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	TIPLE CONS	(X3) DATE SURVEY COMPLETED			
		245350	B. WING		***************************************		-C
NAME OF	PROVIDER OR SUPPLIER	243030	3	STREET	ADDRESS, CITY, STATE, ZIP CODE	12/	22/2017
		BALINITY			NNESOTA BOULEVARD SOUTHEAS	Т	
SIBENE	EDICTS SENIOR COM	MUNITY		SAINT	CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	INITIAL COMMENT A Post Certification December 22, 2017 issued relate to con Benedicts Senior C with 42 CFR Part 4 for Long Term Care The facility is enroll signature is not req page of the CMS-2 correction is require	revisit was conducted on 7, to follow up on deficiencies nplaint H5350061. Stommunity is in compliance 83, subpart B, requirements		C		RIATE	DATE
ADODATOR		DER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITI F		(X6) DATE

12/31/2017

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.

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ R-C B. WING 00774 12/22/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAST ST BENEDICTS SENIOR COMMUNITY SAINT CLOUD, MN 56304 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) {2 000} Initial Comments {2 000} *****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:** A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5350061. St Benedicts Senior Community was found in compliance with state regulations.

Minnesota Department of Health

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

The facility is enrolled in ePOC and therefore a

TITLE

(X6) DATE

12/31/17

PRINTED: 12/31/2017 FORM APPROVED

Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ R-C B. WING 12/22/2017 00774 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1810 MINNESOTA BOULEVARD SOUTHEAST** ST BENEDICTS SENIOR COMMUNITY SAINT CLOUD, MN 56304 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE DATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {2 000} {2 000} Continued From page 1 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.

Minnesota Department of Health

PRINTED: 11/15/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	A. BUILDING		COMPLETED	
		245350	B. WING				C 15/2017
	PROVIDER OR SUPPLIER			18	REET ADDRESS, CITY, STATE, ZIP CODE 110 MINNESOTA BOULEVARD SOUTHEAS AINT CLOUD, MN 56304	-	.0,2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	ITS	F	000			
F 221 SS=D	to investigate case following deficience enrolled in ePOC arequired at the bot CMS-2567 form. POC will be used 483.10(e)(1), 483. FROM PHYSICAL			221			
	§483.10(e) Respe	ct and Dignity.					
	and dignity, includ §483.10(e)(1) The physical or chemic purposes of discip	a right to be treated with respecting: e right to be free from any cal restraints imposed for oline or convenience, and not ne resident's medical symptoms					
	neglect, misappro and exploitation a includes but is not corporal punishmany physical or ch treat the resident's	the right to be free from abuse, priation of resident property, is defined in this subpart. This t limited to freedom from ent, involuntary seclusion and memical restraint not required to a symptoms.					
	(a) The facility mu	ıst-					
	or chemical restra discipline or converged to treat to	e resident is free from physical aints imposed for purposes of enience and that are not he resident's medical in the use of restraints is					
LABORATOR	 RY DIRECTOR'S OR PRO\	/IDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE		TITLE	10500	(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.

Event ID: YFU911

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245350	B. WING	i		11/1	5/2017	
	PROVIDER OR SUPPLIER	MUNITY	······································	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 810 MINNESOTA BOULEVARD SOUTHEAS SAINT CLOUD, MN 56304	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 221	alternative for the I document ongoing restraints. This REQUIREME by: Based on interview failed to ensure restraints for 1 of 7 had a physical restcorresponding ass Findings include: R1's significant chadated 4/10/17, indicognitive impairmed and required exterwith all activities of R1's care plan dat resident was receilife care, had term to provide resident when she the television for FR1's progress note indicated R1 was a by staff sitting in the belt around her was tucked beneath the resident from self wheelchair. The rattempting to stan not able to because restraining R1 in the standard restraining R1 in the st	ty must use the least restrictive east amount of time and re-evaluation of the need for NT is not met as evidenced w and record review, the facility sidents were free from physical residents, R1, reviewed who traint applied by staff with no essment or physician order. ange Minimum Data Set (MDS) cated the resident had severe ent, had no physical restraints, asive assistance of one staff daily living. ed 5/15/17, indicated the ving hospice services for end of inal agitation, and directed staff to one on one time, walk the became agitated, and turn on R1. es dated 7/3/17, at 11:11 a.m. observed the following evening he wheelchair with a transfer last and the belt was behind her e handles to prevent the transferring from the esident was noted to be defrom the wheelchair and was see the transfer belt was		221				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION ING		MPLETED
		245350	B. WING		11	C / 15/2017
	PROVIDER OR SUPPLIER	MUNITY		STREET ADDRESS, CITY, STATE, ZIF 1810 MINNESOTA BOULEVARD S SAINT CLOUD, MN 56304	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 221	where the transfer in the wheelchair. When interviewed on ursing assistant (I overnight shift on 7 a.m. on 7/3/17. Now work that evening a R1 was sitting in he station next to licen NA-K stated R1 waher wheelchair but had a transfer belt was hooked on the secure so R1 was using in her wheelchair but had a transfer belt was hooked on the secure so R1 was using in her wheelchair but attempting to stand approximately an horegistered nurse (Echarge nurse that about the transfer belt removed the belt. The try to stand up out assisted R1 into the footrest. NA-K stated footrest down and applaced a footstool of R1 was unable to go when interviewed stated she worked and R1 was very uniterior was sisted R1 was very uniterior was sisted she worked and R1 was very uniterior was sisted she was	on 7/7/17, at 10:45 a.m. NA)-K stated she worked the /2/17, from 11:00 p.m. to 6:30 a.K stated when arriving to at approximately 11:00 p.m., or wheelchair by the nurses used practical nurse (LPN)-I. is attempting to stand up out of was unable to because she around her waist and the belt back of the wheelchair and unable to remove it. LPN-I ng the transfer belt to keep R1 ecause the resident kept	F 2			
	looped the belt aro to prevent R1 from	oped around R1's waist and und the back of the wheelchair standing. LPN-I did not ysician regarding using a				•

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY
	•		A. DOILL	iiiu			;
		245350	B. WING		Manufacture .	11/1	5/2017
	PROVIDER OR SUPPLIE			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAS SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	a restraint to be used wheelchair. LPN restrained in the alone for a short resident with care NA-N came into wheelchair with the restraining R1 in RN-Q. LPN-I statement of the strain of the several times was not safe to we restrained R1 in belt several times did prevent R1 frestated she had used in reclining chair for was restless and LPN-I stated this had attempted to if she was not about the several times and the several times was restless and the several times and the several times are stated to the several times and the several times and the several times are stated to the several times and the several times are stated to the	page 3 and there was no order directing used to keep R1 in the -I stated when R1 was wheelchair she had to leave her time while assisting another es. When LPN-I walked away, the unit and observed R1 in the ne transfer belt around her waist the wheelchair and notified ted RN-Q told her to remove the around the wheelchair because LPN-I stated R1 was difficult to she was always moving and valk. LPN-I stated she had the wheelchair using the transfer in the past three weeks and it om self transferring. LPN-I sed a footstool under the otrest for R1 when the resident attempting to stand. However, wasn't the best options as R1 orawl off the side of the recliner let to lower the footrest.	F	221			
	NA-N stated she 7/2/17-7/3/17. N safety audits of t R1's unit on 7/3/NA-N was unable sitting in her whethe brakes locke a blanket around to become restle and the blanket is saw R1 was beir by a transfer belt called RN-Q and	worked the overnight shift on A-N stated she was conducting he facility. When arriving on 17, at approximately 1:30 a.m. e to locate any staff. R1 was selchair by the nurses desk with d on the wheelchair and R1 had her lap. NA-N stated R1 started as and attempted to stand up fell off her lap. NA-N stated she ag restrained into the wheelchair and was unable to stand. NA-N requested he come to the unit a-N stated about 8 minutes					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		COMPLETED				
		245350	B. WING			11/1	; 5/2017
	ROVIDER OR SUPPLIER	IMUNITY		1	STREET ADDRESS, CITY, STATE, ZIP CODE 810 MINNESOTA BOULEVARD SOUTHEAS SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) , COMPLETION DATE
F 221	she saw any staff f During interview or stated she worked 6/27/17-6/28/17, w attempting to stand forward in the whewrapped a bedshe around the back of from standing up, restrained in the whours.	me she came onto the unit until	F2	221			
F 225 SS=D	3/2008, indicated pthe nurse would intresponsible party coircumstances relapotential risk and brestraints, and alterestraint required amedical reason, duand observation arrestraint. Emerger specific documents emergency necess physician order, rerepresentative infortype of restraint, approtocol. 483.12(a)(3)(4)(c)(ALLEGATIONS/IN	orior to the use of any restraint form the resident and/or the of the resident's condition and atted to restraint use, the benefits related to use of rnatives to restraint use. Any a physician order indicating the uration of use, type of restraint, and release protocol for the necy use of a restraint required ed interventions including sitating restraint use, the sident and/or legal armed consent, duration of use, and observation and release (1)-(4) INVESTIGATE/REPORT DIVIDUALS	F	225			
	(3) Not employ or who-	otherwise engage individuals					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						C	l l
		245350	B. WING		The state of the s	11/1	5/2017
	STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304			Т			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPIDEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From pa	age 5	F	225			
		d guilty of abuse, neglect, propriation of property, or court of law;					
	nurse aide registry	ing entered into the State concerning abuse, neglect, atment of residents or f their property; or					
	or her professional body as a result of	nary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or f resident property.					
	licensing authoritie actions by a court	tate nurse aide registry or sany knowledge it has of of law against an employee, te unfitness for service as a refacility staff.					
		allegations of abuse, neglect, treatment, the facility must:					
	abuse, neglect, exincluding injuries of misappropriation of reported immediate after the allegation cause the allegation serious bodily injure the events that cause and do not in the administrator of officials (including	alleged violations involving ploitation or mistreatment, funknown source and fresident property, are ely, but not later than 2 hours is made, if the events that on involve abuse or result in ry, or not later than 24 hours if use the allegation do not involve result in serious bodily injury, to of the facility and to other to the State Survey Agency and rvices where state law provides					

STATEMENT OF DEFICIENCIES (X1) F		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING .			PLETED
		245350	B. WING			C 11 /1	5/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, .	<u> </u>
ST BENE	EDICTS SENIOR COM	IMUNITY			810 MINNESOTA BOULEVARD SOUTHEAS AINT CLOUD, MN 56304	Т	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	for jurisdiction in loaccordance with St procedures. (2) Have evidence thoroughly investig. (3) Prevent further exploitation, or mis investigation is in p. (4) Report the result administrator or his representative and with State law, included and interview failed to ensure allowere reported for 1 who were physicall without a physician Findings include: R1's significant characteristic impairment and required extendit with all activities of R1's care plan data resident was received if e care, had termined and ter	that all alleged violations are ated. potential abuse, neglect, treatment while the rogress. Its of all investigations to the sor her designated to other officials in accordance uding to the State Survey orking days of the incident, and ion is verified appropriate just be taken. NT is not met as evidenced w and record review, the facility egations of staff mistreatment of 7 residents, R1, reviewed by restrained in their wheelchair a order or medical justification.		225			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245350	B. WING			11/1	5/2017
	PROVIDER OR SUPPLIER	IMUNITY		1	TREET ADDRESS, CITY, STATE, ZIP CODE 810 MINNESOTA BOULEVARD SOUTHEAS SAINT CLOUD, MN 56304		•
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	indicated R1 was of wheelchair with a transferring from the shift on 7/2/17-7/3/ be attempting to st was not able to be restraining R1 in the A progress note daindicated there was where the transfer in the wheelchair. The facility incident the facility reported wheelchair to the secured and assistant (overnight shift on 7 a.m. on 7/3/17. Nowork that evening R1 was sitting in he station next to licent NA-K stated R1 was hooked on the secured so R1 was LPN-I stated she was LPN-I stated register.	s dated 7/3/17, at 11:11 a.m. bserved by staff sitting in the ransfer belt around her waist which her tucked beneath the the resident from self wheelchair during the night 17. The resident was noted to and from the wheelchair and cause the transfer belt was		225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILL	nivo		c	;	
		245350	B. WING	·		11/1	5/2017	
.,,,	PROVIDER OR SUPPLIEF EDICTS SENIOR COI			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAS SAINT CLOUD, MN 56304	т		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 225	R1, so LPN-I remoderation and LPN-I assiste elevated the footres to push the footres so LPN-I placed a footrest so R1 was recliner. NA-K state anyone at the faci. When interviewed stated she worked and R1 was very stand from the what a transfer belt was belt around the basecured the belt to LPN-I stated she wheelchair using the past three westransferring. LPN-footstool under the when the resident stand. LPN-I state could not be used best option to kee falling. When interviewed stated approximal attempted to put the wheelchair to wheelchair. NA-J restraining R1 wit	about the transfer belt around oved the belt. NA-K stated R1 stand up out of the wheelchair, d R1 into the recliner and est. NA-K stated R1 was able at down and attempt to stand, footstool under the recliner is unable to get out of the atted she did not report this to		225				
		A-J stated she only attempted n the wheelchair with the						

			(X3) DATE COMF	SURVEY PLETED			
						c	
		245350	B. WING			11/1	5/2017
	PROVIDER OR SUPPLIER EDICTS SENIOR COM	IMUNITY		1	STREET ADDRESS, CITY, STATE, ZIP CODE 810 MINNESOTA BOULEVARD SOUTHEAS SAINT CLOUD, MN 56304	Γ	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	okay to do that, and trouble." NA-J statkeep R1 in the recl footrest and placing so R1 could not pure of the chair. Howe out of the chair. Howe out of the chair so so when interviewed administrator state report allegations of administrator states being restrained, the immediately to admagency. During interview or stated she worked 6/27/17-6/28/17, where was the worked forward in the where wrapped a bedshed around the back of from standing up, restrained in the whours. RN-H state LPN-I restraining Facility until 7/3/17, about LPN-I restrainte transfer belt the 7/2/17-7/3/17. Although multiple so was restrained in the reported to the address of the undated facility undated faci	se she wasn't sure if it was d she, "Didn't want to get into ed she had also attempted to iner by putting up the reclining g a footstool under the footrest the footrest down and get out ver, R1 would attempt to climb staff had to watch her closely. On 7/7/17, at 2:30 p.m. the d all staff are responsible to of staff mistreatment. The d if staff were aware R1 was his should have been reported ministration and to the state On 7/20/17, at 11:10 a.m. RN-H an overnight shift on ith LPN-I. R1 was restless, if and walk, and was leaning elchair. RN-H stated LPN-I et around R1's waist and tied it the wheelchair to prevent R1 RN-H stated R1 was neelchair approximately 3-4 d she felt uncomfortable with R1, but didn't report it to the after hearing from other staff ining R1 in the wheelchair with	F	225			

PRINTED: 11/15/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		· ·	(X3) DATE SURVEY COMPLETED	
		245350	B. WING			11/1	5 1 5/2017
	PROVIDER OR SUPPLIER	MUNITY		181	REET ADDRESS, CITY, STATE, ZIP CODE 10 MINNESOTA BOULEVARD SOUTHEAS NINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225 F 226 SS=D	were to reported im and the state agent suspected of abuse resident the admini may relieve/susper leave the individual investigation is con 483.12(b)(1)-(3), 48	eatment, neglect, or abuse immediately to the administrator cy. If a staff member was e, neglect, or maltreatment of a strator or director of nursing ind, or place on administrative of their duties until the inplete.		225			
	written policies and (1) Prohibit and pre exploitation of resident property, (2) Establish policie investigate any sud (3) Include training §483.95, 483.95 (c) Abuse, neglect, the freedom from a requirements in § 4 provide training to educates staff on- (c)(1) Activities tha exploitation, and m property as set forter	event abuse, neglect, and dents and misappropriation of dents and procedures to the allegations, and as required at paragraph and exploitation. In addition to abuse, neglect, and exploitation 483.12, facilities must also their staff that at a minimum to constitute abuse, neglect, hisappropriation of resident					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' ′		E CONSTRUCTION	COMP	LETED
		245350	B. WING				5/2017
,,,,,,,	PROVIDER OR SUPPLIER			18	FREET ADDRESS, CITY, STATE, ZIP CODE B10 MINNESOTA BOULEVARD SOUTHEAS AINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	neglect, exploitation resident property (c) (3) Dementia man prevention. This REQUIREMED by: Based on interview failed to implement of mistreatment to agency according residents, R1, revirestrained in their order or medical justice. The undated facility Adults- Abuse Preallegations of mist were to reported in and the state ager suspected of abus resident the admirmay relieve/suspe	anagement and resident abuse and record review, the facility their policy to report incidents the administrator and the state to the facility policy for 1 of 7 ewed who were physically wheelchair without a physician ustification. Ty policy titled Vulnerable vention Policy, indicated all reatment, neglect, or abuse mmediately to the administrator and, or place on administrative all of their duties until the		226	DEFICIENCY)		
	indicated R1 was a wheelchair with a and the belt was be handles to prevent ransferring from the shift on 7/2/17-7/3 be attempting to s	es dated 7/3/17, at 11:11 a.m. observed by staff sitting in the transfer belt around her waist behind her tucked beneath the t the resident from self the wheelchair during the night 1/17. The resident was noted to tand from the wheelchair and ecause the transfer belt was he wheelchair.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	ING		MPLETED
		245350	B. WING		11	C / 15/2017
	PROVIDER OR SUPPLIER	MUNITY		STREET ADDRESS, CITY, STATE 1810 MINNESOTA BOULEVAR SAINT CLOUD, MN 56304	, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 226	The facility incident the facility reported restrained in the whole when interviewed and R1 was very ustand from the wheat ransfer belt wrap looped the belt around secured it to provide the stated she had restrusing the transfer betweeks to prevent three weeks to prevent was restless and astated she was away used, however, she keep R1 safe to prevent was restless and astated approximate attempted to put the waist and hook it of the wheelchair. NA-J serestraining R1 with told her she could rethe wheelchair. NA-attempted to keep the reclining footres under the footrest she down and get out of would attempt to clinad to watch her cliving when interviewed would attempt to clinad to watch her cliving was restricted.	report dated 7/3/17, indicated to the state agency R1 was neelchair on 7/3/17. on 7/7/17, at 11:10 a.m. LPN-I the overnight shift on 7/2/17, insteady and attempting to relchair. LPN-I stated she used uped around R1's waist and und the back of the wheelchair revent R1 from standing. LPN-I trained R1 in the wheelchair revent R1 from self transferring. Iso used a footstool under the rest for R1 when the resident thempting to stand. LPN-I are restraints could not be refelt it was the best option to revent her from falling. on 7/7/17, at 1:40 p.m. NA-July two weeks ago she retransfer belt around R1's into the handles on the back of rep R1 from standing up in the stated LPN-I asked her about the transfer belt, but never not use the belt to keep R1 in A-J stated she had also R1 in the recliner by putting up st and placing a footstool so R1 could not put the footrest of the chair. However, R1 imb out of the chair so staff	F2	226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION DING	(X3	COMPLETED	
		245350	B. WING			C 11/15/2017
	PROVIDER OR SUPPLIER	IMUNITY		STREET ADDRESS, CITY, STATE, ZI 1810 MINNESOTA BOULEVARD SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIAT	
F 226	report allegations of administrator state being restrained, the to administration a according to the far according to the far according interview or stated she worked 6/27/17-6/28/17, where was a state of the worked forward in the whee wrapped a bedshe around the back of from standing up. restrained in the whours. RN-H state LPN-I restraining Facility according to after hearing from restraining R1 in the belt the prior evenion of the several state of the several stat	of staff mistreatment. The d if staff were aware R1 was his should have been reported and to the state agency cility policy. In 7/20/17, at 11:10 a.m. RN-H an overnight shift on with LPN-I. R1 was restless, d and walk, and was leaning elchair. RN-H stated LPN-I et around R1's waist and tied it if the wheelchair to prevent R1 RN-H stated R1 was heelchair approximately 3-4 and she felt uncomfortable with R1, but didn't report it to the pother staff about LPN-I he wheelchair with the transfering on 7/2/17-7/3/17.		226		

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ___ C **B WING** 11/15/2017 00774 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAST ST BENEDICTS SENIOR COMMUNITY SAINT CLOUD, MN 56304 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 2 000 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:** A complaint investigation was conducted to investigate complaint #H5350061. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at

Minnesota Department of Health

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnoco	ta Department of He	alth			I OHIVI A	MITTOVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00774	B. WING		C 11/15	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	EDICTS SENIOR COM	RALINITY	NESOTA BOU OUD, MN 56	JLEVARD SOUTHEAST 3304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 505	http://www.health.sobul.htm The State delineated on the and Department of Hear electronically. Althonecessary for State the word "corrected. Then indicate in the process, under the date your orders welectronically submodepartment of Hear MN Rule 4658.030 Restraints Subpart 1. Definiting the following terms: A. "Physical remethod or physical material, or equipment or normodefine president's body remove easily which movement or normodefinition of a restraints also include finition of a restraint so tightly that a resumove; bed rails; cholding a resident wall that the wall prising. Bed rails and restrict freedom of used solely to assist help the resident of the state of the	tate.mn.us/divs/fpc/profinfo/inf te licensing orders are ttached Minnesota alth orders being submitted ough no plan of correction is e Statutes/Rules, please enter d" in the box available for text. the electronic State licensure heading completion date, the fill be corrected prior to bitting to the Minnesota		DEFICIENCY		

Minnesota Department of Health

Minneso	ta Department of He	ealth				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00774	B. WING		11/1	; 5/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ST BENE	EDICTS SENIOR COM	MIINITY	NESOTA BOI OUD, MN 56	ULEVARD SOUTHEAST 3304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 505	Continued From pa	ige 2	2 505			
	staff that a resident not, in and of thems movement and shorestraints. B. "Chemical repsychopharmacolo discipline or converteat medical symp C. "Discipline" nursing home for the penalizing a reside D. "Convenien solely to control resident with a less in the resident's be E. "Emergency immediate action in the solely to control resident with a less in the resident's be E. "Emergency immediate action in the solely to control resident with a less in the resident's be E. "Emergency immediate action in the solely to control resident's be E. "Emergency immediate action in the solely	means any action taken by the ne purpose of punishing or nt. ce" means any action taken sident behavior or maintain a ter amount of effort that is not st interest. If measures" means the necessary to alleviate an on or sudden occurrence of a				
	by: Based on interview failed to ensure restraints for 1 of 7 had a physical rest corresponding ass Findings include: R1's significant chadated 4/10/17, indicognitive impairment and required exten with all activities of					
	R1's care plan date resident was received	ed 5/15/17, indicated the ving hospice services for end of	f		•	

Minnesota Department of Health

YFU911

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: C B. WING 11/15/2017 00774 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1810 MINNESOTA BOULEVARD SOUTHEAST ST BENEDICTS SENIOR COMMUNITY SAINT CLOUD, MN 56304 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 5 0 5 2 5 0 5 Continued From page 3 life care, had terminal agitation, and directed staff to provide resident one on one time, walk the resident when she became agitated, and turn on the television for R1. R1's progress notes dated 7/3/17, at 11:11 a.m. indicated R1 was observed the following evening by staff sitting in the wheelchair with a transfer belt around her waist and the belt was behind her tucked beneath the handles to prevent the resident from self transferring from the wheelchair. The resident was noted to be attempting to stand from the wheelchair and was not able to because the transfer belt was restraining R1 in the wheelchair. A progress note dated 7/3/17, at 1:55 p.m. indicated there was no bruising noted to R1 where the transfer belt was placed to restrain her in the wheelchair. When interviewed on 7/7/17, at 10:45 a.m. nursing assistant (NA)-K stated she worked the overnight shift on 7/2/17, from 11:00 p.m. to 6:30 a.m. on 7/3/17. NA-K stated when arriving to work that evening at approximately 11:00 p.m., R1 was sitting in her wheelchair by the nurses station next to licensed practical nurse (LPN)-I. NA-K stated R1 was attempting to stand up out of her wheelchair but was unable to because she had a transfer belt around her waist and the belt was hooked on the back of the wheelchair and secure so R1 was unable to remove it. LPN-I stated she was using the transfer belt to keep R1 in her wheelchair because the resident kept attempting to stand up. NA-K stated approximately an hour later LPN-I stated registered nurse (RN)-Q, who was also the charge nurse that evening, had questioned LPN-I

Minnesota Department of Health

about the transfer belt around R1, so LPN-I

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	` '		(X3) DATE SURVEY COMPLETED					
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774	B. WING		1	5/2017				
STREET ADD	DRESS, CITY, S	TATE, ZIP CODE						
1810 MINN	NESOTA BOL	ILEVARD SOUTHEAST						
SAINT CL	OUD, MN 56	304						
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	2 505							
neelchair, and LPN-I r and elevated the ras able to push the to stand, so LPN-I e recliner footrest so a the recliner. 7, at 11:10 a.m. LPN-I right shift on 7/2/17, and attempting to LPN-I stated she used und R1's waist and back of the wheelchair g. LPN-I did not egarding using a vas no order directing ep R1 in the when R1 was r she had to leave her assisting another LPN-I walked away, and observed R1 in the r belt around her waist chair and notified told her to remove the ne wheelchair because ated R1 was difficult to always moving and l-I stated she had chair using the transfer st three weeks and it ansferring. LPN-I stool under the R1 when the resident g to stand. However, e best options as R1	2 303							
	1810 MINI	STREET ADDRESS, CITY, S' 1810 MINNESOTA BOL SAINT CLOUD, MN 56 PRECEDED BY FULL FYING INFORMATION) 2 505 ated R1 continued to neelchair, and LPN-I rand elevated the vas able to push the to stand, so LPN-I e recliner footrest so f the recliner. 7, at 11:10 a.m. LPN-I rand attempting to LPN-I stated she used und R1's waist and back of the wheelchair g. LPN-I did not egarding using a was no order directing ep R1 in the when R1 was reshe had to leave her assisting another LPN-I walked away, and observed R1 in the relation to the wheelchair because ated R1 was difficult to always moving and lestated she had chair using the transfer ast three weeks and it ansferring. LPN-I stool under the R1 when the resident got ostand. However, the best options as R1 the side of the recliner	STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULLEVARD SOUTHEAST SAINT CLOUD, MN 56304 DE DEFICIENCIES PRECEDED BY FULL PRIEFIX TAG PROVIDER'S PLAN OF CORRECTIFY ACTION SHOULE CROSS-REFERENCED TO THE APPRODE DEFICIENCY) ated R1 continued to neelchair, and LPN-I and elevated the rass able to push the to stand, so LPN-I e recliner footrest so f the recliner. 7, at 11:10 a.m. LPN-I might shift on 7/2/17, and attempting to LPN-I stated she used und R1's waist and back of the wheelchair g. LPN-I did not egarding using a was no order directing ep R1 in the vhen R1 was r she had to leave her assisting another LPN-I walked away, do observed R1 in the r belt around her waist chair and notified told her to remove the ewheelchair because ated R1 was difficult to always moving and -1 stated she had chair using the transfer ist three weeks and it ansferring. LPN-I stool under the R1 when the resident g to stand. However, a best options as R1 the side of the recliner	STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304 PRECIDED BY FULL PREFIX TAG PRECIDED BY FULL TAG 2 505 Ated R1 continued to leelchair, and LPN-1 are delevated the reas able to push the to stand, so LPN-1 are delimined back of the wheelchair g. LPN-1 did not egarding using a was no order directing ep R1 in the when R1 was reshe had to leave her existing another LPN-1 walked away, did observed R1 in the r belt around her waist chair and notified told her to remove the ewheelchair because ated R1 was difficult to always moving and -I stated she had chair using the transfer ist three weeks and it ansferring, LPN-1 stool under the R1 when the resident got stand. However, a best options as R1 the side of the recliner				

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C **B WING** 11/15/2017 00774 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1810 MINNESOTA BOULEVARD SOUTHEAST ST BENEDICTS SENIOR COMMUNITY SAINT CLOUD, MN 56304 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 5 0 5 2 505 Continued From page 5 When interviewed on 7/17/17, at 12:20 p.m. NA-N stated she worked the overnight shift on 7/2/17-7/3/17. NA-N stated she was conducting safety audits of the facility. When arriving on R1's unit on 7/3/17, at approximately 1:30 a.m. NA-N was unable to locate any staff. R1 was sitting in her wheelchair by the nurses desk with the brakes locked on the wheelchair and R1 had a blanket around her lap. NA-N stated R1 started to become restless and attempted to stand up and the blanket fell off her lap. NA-N stated she saw R1 was being restrained into the wheelchair by a transfer belt and was unable to stand. NA-N called RN-Q and requested he come to the unit immediately. NA-N stated about 8 minutes passed from the time she came onto the unit until she saw any staff from the unit. During interview on 7/20/17, at 11:10 a.m. RN-H stated she worked an overnight shift on 6/27/17-6/28/17, with LPN-I. R1 was restless, attempting to stand and walk, and was leaning forward in the wheelchair. RN-H stated LPN-I wrapped a bedsheet around R1's waist and tied it around the back of the wheelchair to prevent R1 from standing up. RN-H stated R1 was restrained in the wheelchair approximately 3-4 hours. The facility policy titled Restraints- Physical dated 3/2008, indicated prior to the use of any restraint the nurse would inform the resident and/or the responsible party of the resident's condition and circumstances related to restraint use, the potential risk and benefits related to use of restraints, and alternatives to restraint use. Any restraint required a physician order indicating the medical reason, duration of use, type of restraint,

Minnesota Department of Health

and observation and release protocol for the restraint. Emergency use of a restraint required

6899

PRINTED: 11/15/2017 FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ C B. WING 11/15/2017 00774 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1810 MINNESOTA BOULEVARD SOUTHEAST ST BENEDICTS SENIOR COMMUNITY SAINT CLOUD, MN 56304 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 505 2 505 Continued From page 6 specific documented interventions including emergency necessitating restraint use, the physician order, resident and/ or legal representative informed consent, duration of use, type of restraint, and observation and release protocol. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding physical restraint use. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 21850 MN St. Statute 144.651 Subd. 14 Patients & 21850 Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a

others.

resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to

This MN Requirement is not met as evidenced

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Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ___ 11/15/2017 00774 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1810 MINNESOTA BOULEVARD SOUTHEAST ST BENEDICTS SENIOR COMMUNITY SAINT CLOUD, MN 56304 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21850 21850 Continued From page 7 by: Based on interview and record review the facility failed to ensure 1 of 7 residents, R1, were free from abuse when the resident was physically restrained in the wheelchair multiple times by a staff member without medical justification and a physician order. Findings include: R1's significant change Minimum Data Set (MDS) dated 4/10/17, indicated the resident had severe cognitive impairment, had no physical restraints, and required extensive assistance of one staff with all activities of daily living. R1's care plan dated 5/15/17, indicated the resident was receiving hospice services for end of life care, had terminal agitation, and directed staff to provide resident one on one time, walk the resident when she became agitated, and turn on the television for R1. R1's progress notes dated 7/3/17, at 11:11 a.m. indicated R1 was observed the following evening by staff sitting in the wheelchair with a transfer belt around her waist and the belt was behind her tucked beneath the handles to prevent the resident from self transferring from the wheelchair. The resident was noted to be attempting to stand from the wheelchair and was not able to because the transfer belt was restraining R1 in the wheelchair. A progress note dated 7/3/17, at 1:55 p.m. indicated there was no bruising noted to R1 where the transfer belt was placed to restrain her in the wheelchair.

Minnesota Department of Health STATE FORM

When interviewed on 7/7/17, at 10:45 a.m.

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE COMP	SURVEY
		00774	B. WING		11/1	5/2017
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		
ST BENE	EDICTS SENIOR COM	INNI INIITV	NESOTA BOU LOUD, MN 56	JLEVARD SOUTHEAST 304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21850	Continued From particles of the particle	age 8 NA)-K stated she worked the 7/2/17, from 11:00 p.m. to 6:30 A-K stated when arriving to at approximately 11:00 p.m., er wheelchair by the nurses used practical nurse (LPN)-I. as attempting to stand up out of was unable to because she around her waist and the belt back of the wheelchair and unable to remove it. LPN-I ung the transfer belt to keep R1 because the resident kept dup. NA-K stated hour later LPN-I stated RN)-Q, who was also the evening, had questioned LPN-I belt around R1, so LPN-I NA-K stated R1 continued to of the wheelchair, and LPN-I e recliner and elevated the ted R1 was able to push the attempt to stand, so LPN-I under the recliner footrest so get out of the recliner. on 7/7/17, at 11:10 a.m. LPN-I the overnight shift on 7/2/17, ansteady and attempting to be ped around R1's waist and bund the back of the wheelchair astanding. LPN-I did not a standing. LPN-I did not a standing. LPN-I did not a stated when R1 was	21850			
	alone for a short ti	heelchair she had to leave her me while assisting another s. When LPN-I walked away,				

Minnesota Department of Health

6899

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: C 11/15/2017 00774 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1810 MINNESOTA BOULEVARD SOUTHEAST ST BENEDICTS SENIOR COMMUNITY SAINT CLOUD, MN 56304 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21850 Continued From page 9 21850 NA-N came into the unit and observed R1 in the wheelchair with the transfer belt around her waist restraining R1 in the wheelchair and notified RN-Q. LPN-I stated RN-Q told her to remove the transfer belt from around the wheelchair because it was a restraint. LPN-I stated R1 was difficult to monitor because she was always moving and was not safe to walk. LPN-I stated she had restrained R1 in the wheelchair using the transfer belt several times in the past three weeks and it did prevent R1 from self transferring. LPN-I stated she had used a footstool under the reclining chair footrest for R1 when the resident was restless and attempting to stand. However, LPN-I stated this wasn't the best options as R1 had attempted to crawl off the side of the recliner if she was not able to lower the footrest. When interviewed on 7/17/17, at 12:20 p.m. NA-N stated she worked the overnight shift on 7/2/17-7/3/17. NA-N stated she was conducting safety audits of the facility. When arriving on R1's unit on 7/3/17, at approximately 1:30 a.m. NA-N was unable to locate any staff. R1 was sitting in her wheelchair by the nurses desk with the brakes locked on the wheelchair and R1 had a blanket around her lap. NA-N stated R1 started to become restless and attempted to stand up and the blanket fell off her lap. NA-N stated she saw R1 was being restrained into the wheelchair by a transfer belt and was unable to stand. NA-N called RN-Q and requested he come to the unit immediately. NA-N stated about 8 minutes passed from the time she came onto the unit until she saw any staff from the unit. During interview on 7/20/17, at 11:10 a.m. RN-H stated she worked an overnight shift on 6/27/17-6/28/17, with LPN-I. R1 was restless,

Minnesota Department of Health

attempting to stand and walk, and was leaning

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PRINTED: 11/15/2017 **FORM APPROVED** Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ C B. WING 11/15/2017 00774 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAST ST BENEDICTS SENIOR COMMUNITY SAINT CLOUD, MN 56304 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21850 21850 Continued From page 10 forward in the wheelchair. RN-H stated LPN-I wrapped a bedsheet around R1's waist and tied it around the back of the wheelchair to prevent R1 from standing up. RN-H stated R1 was restrained in the wheelchair approximately 3-4 hours. The facility policy titled Restraints- Physical dated 3/2008, indicated prior to the use of any restraint the nurse would inform the resident and/or the responsible party of the resident's condition and circumstances related to restraint use, the potential risk and benefits related to use of restraints, and alternatives to restraint use. Any restraint required a physician order indicating the medical reason, duration of use, type of restraint, and observation and release protocol for the restraint. Emergency use of a restraint required specific documented interventions including emergency necessitating restraint use, the physician order, resident and/ or legal representative informed consent, duration of use. type of restraint, and observation and release protocol. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure each resident's bill of rights are upheld and residents are free from maltreatment. The Director of Nursing or

Minnesota Department of Health

(21) Days

designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty One

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	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	DENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
)
		00774	B. WING		I	5/2017
NAME OF F	DOVIDED OD SUDDUED	STREET AD	DRESS CITY S	STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			ULEVARD SOUTHEAST		
ST BENE	DICTS SENIOR COM	MINITY	OUD, MN 56			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
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21980	Continued From pa	ge 11	21980			:
21980	MN St. Statute 626	.557 Subd. 3 Reporting -	21980			
	Maltreatment of Vu					
						-
		of report. (a) A mandated				-
		eason to believe that a				
		being or has been maltreated,				
		dge that a vulnerable adult ysical injury which is not				
		ed shall immediately report the				
		common entry point. If an				
		erable adult solely because	1			
		nitted to a facility, a mandated				
		ired to report suspected				
		e individual that occurred prior				
	to admission, unles	ss:				
	(1) the individual w	as admitted to the facility from				
		the reporter has reason to				
		ble adult was maltreated in the				
	previous facility; or					
		knows or has reason to believe				
		s a vulnerable adult as defined				
		2, subdivision 21, clause (4).				
	, , ,	required to report under the				
	as described above	ection may voluntarily report				
		s section requires a report of				
		d maltreatment, if the reporter				
		on to know that a report has				
		common entry point.				
		s section shall preclude a				
	'	reporting to a law enforcement				
	agency.	ranartar who knows or has				
		reporter who knows or has nat an error under section				
		ion 17, paragraph (c), clause				
		make a report under this				
		reporter or a facility, at any				
		an investigation by a lead				

Minnesota Department of Health

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00774	B. WING		C 11/1	5/2017		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD		TATE, ZIP CODE				
ST BENE	DICTS SENIOR COM		NESOTA BOU OUD, MN 56	JLEVARD SOUTHEAST 6304				
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21980	Continued From pa	ige 12	21980					
21900	agency will determithe reported error withe criteria under set 17, paragraph (c), of facility may provided directly to the lead how the event mee 626.5572, subdivisi (5). The lead ager information when mithe report under sufficient under sufficient to ensure allewere reported for 1 who were physicall without a physiciant without a physiciant Findings include: R1's significant character and required exten with all activities of R1's care plan date resident was receivable for the television for R1.	ine or should determine that was not neglect according to ection 626.5572, subdivision clause (5), the reporter or e to the common entry point or agency information explaining its the criteria under section ion 17, paragraph (c), clause ney shall consider this naking an initial disposition of abdivision 9c. ent is not met as evidenced and record review, the facility egations of staff mistreatment of 7 residents, R1, reviewed by restrained in their wheelchair a order or medical justification. ange Minimum Data Set (MDS) cated the resident had severe ent, had no physical restraints, asive assistance of one staff daily living. ed 5/15/17, indicated the ving hospice services for end of inal agitation, and directed staff one on one time, walk the became agitated, and turn on						
	indicated R1 was of wheelchair with a t	es dated 7/3/17, at 11:11 a.m. observed by staff sitting in the transfer belt around her waist ehind her tucked beneath the						

Minnesota Department of Health

PRINTED: 11/15/2017 FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: __ C 11/15/2017 00774 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1810 MINNESOTA BOULEVARD SOUTHEAST ST BENEDICTS SENIOR COMMUNITY SAINT CLOUD, MN 56304 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21980 21980 Continued From page 13 handles to prevent the resident from self transferring from the wheelchair during the night shift on 7/2/17-7/3/17. The resident was noted to be attempting to stand from the wheelchair and was not able to because the transfer belt was restraining R1 in the wheelchair. A progress note dated 7/3/17, at 1:55 p.m. indicated there was no bruising noted to R1 where the transfer belt was placed to restrain her in the wheelchair. The facility incident report dated 7/3/17, indicated the facility reported R1 was restrained in the wheelchair to the state agency on 7/3/17. When interviewed on 7/7/17, at 10:45 a.m. nursing assistant (NA)-K stated she worked the overnight shift on 7/2/17, from 11:00 p.m. to 6:30 a.m. on 7/3/17. NA-K stated when arriving to work that evening at approximately 11:00 p.m., R1 was sitting in her wheelchair by the nurses station next to licensed practical nurse (LPN)-I. NA-K stated R1 was attempting to stand up out of her wheelchair but was unable to because she had a transfer belt around her waist and the belt was hooked on the back of the wheelchair and secured so R1 was not able to remove the belt. LPN-I stated she was using the transfer belt on R1 because the resident kept attempting to stand

Minnesota Department of Health

up. NA-K stated approximately an hour later LPN-I stated registered nurse (RN)-Q, who was

questioned LPN-I about the transfer belt around R1, so LPN-I removed the belt. NA-K stated R1 continued to try to stand up out of the wheelchair, and LPN-I assisted R1 into the recliner and elevated the footrest. NA-K stated R1 was able to push the footrest down and attempt to stand, so LPN-I placed a footstool under the recliner

also the charge nurse that evening, had

Minnesote Department of Health							
Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
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00774		B. WING			11/15/2017		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
ST BENEDICTS SENIOR COMMUNITY 1810 MINNESOTA BOULEVARD SOUTHEAST SAINT CLOUD, MN 56304							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETE		
21980	Continued From page 14		21980				
	footrest so R1 was unable to get out of the recliner. NA-K stated she did not report this to anyone at the facility.						
	When interviewed on 7/7/17, at 11:10 a.m. LPN-I stated she worked the overnight shift on 7/2/17, and R1 was very unsteady and attempting to stand from the wheelchair. LPN-I stated she used a transfer belt wrapped around R1 and looped the belt around the back of the wheelchair and secured the belt to prevent R1 from standing. LPN-I stated she had restrained R1 in the wheelchair using the transfer belt several times in the past three weeks to prevent R1 from self transferring. LPN-I stated she also used a footstool under the reclining chair footrest for R1 when the resident was restless and attempting to stand. LPN-I stated she was aware restraints could not be used, however, she felt it was the best option to keep R1 safe to prevent her from falling.						
	stated approximate attempted to put the waist and hook it on the wheelchair to know wheelchair. NA-J is restraining R1 with told her she could be wheelchair. NA once to keep R1 in transfer belt becaut okay to do that, and trouble." NA-J state keep R1 in the reception of the could not put the wheelchair.	on 7/7/17, at 1:40 p.m. NA-Jely two weeks ago she e transfer belt around R1's nto the handles on the back of eep R1 from standing up in the stated LPN-I asked her about the transfer belt, but never not use the belt to keep R1 in L-J stated she only attempted the wheelchair with the se she wasn't sure if it was d she, "Didn't want to get into ted she had also attempted to liner by putting up the reclining g a footstool under the footrest it the footrest down and get out over, R1 would attempt to climb					

Minnesota Department of Health

6899

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: С 11/15/2017 00774 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1810 MINNESOTA BOULEVARD SOUTHEAST ST BENEDICTS SENIOR COMMUNITY SAINT CLOUD, MN 56304 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21980 Continued From page 15 21980 When interviewed on 7/7/17, at 2:30 p.m. the administrator stated all staff are responsible to report allegations of staff mistreatment. The administrator stated if staff were aware R1 was being restrained, this should have been reported immediately to administration and to the state agency. During interview on 7/20/17, at 11:10 a.m. RN-H stated she worked an overnight shift on 6/27/17-6/28/17, with LPN-I. R1 was restless, attempting to stand and walk, and was leaning forward in the wheelchair. RN-H stated LPN-I wrapped a bedsheet around R1's waist and tied it around the back of the wheelchair to prevent R1 from standing up. RN-H stated R1 was restrained in the wheelchair approximately 3-4 hours. RN-H stated she felt uncomfortable with LPN-I restraining R1, but didn't report it to the facility until 7/3/17, after hearing from other staff about LPN-I restraining R1 in the wheelchair with the transfer belt the prior evening on 7/2/17-7/3/17. Although multiple staff members were aware R1 was restrained in the wheelchair, this was not reported to the administrator or the state agency. The undated facility policy titled Vulnerable Adults- Abuse Prevention Policy, indicated all allegations of mistreatment, neglect, or abuse were to reported immediately to the administrator and the state agency. If a staff member was suspected of abuse, neglect, or maltreatment of a resident the administrator or director of nursing may relieve/suspend, or place on administrative leave the individual of their duties until the investigation is complete.

Minnesota Department of Health STATE FORM

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Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: ___ C B. WING 11/15/2017 00774 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1810 MINNESOTA BOULEVARD SOUTHEAST ST BENEDICTS SENIOR COMMUNITY SAINT CLOUD, MN 56304 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21980 21980 Continued From page 16 SUGGESTED METHOD OF CORRECTION: The administrator or designee could provide education to facility staff on reporting allegations of maltreatment to the state agency. The administrator or designee could ensure residents safety and well being by providing supervision and education to facility staff on abuse and neglect. The administrator or designee could provide monitoring for compliance in reporting allegations of maltreatment and could provide monitoring for resident safety. TIME PERIOD FOR CORRECTION: Twenty One (21) Days

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