

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 15, 2020

Administrator St Benedicts Senior Community 1810 Minnesota Boulevard Southeast Saint Cloud, MN 56304

SUBJECT: SURVEY RESULTS CCN: 245350 Cycle Start Date: April 30, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit <u>https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0</u>.

SURVEY RESULTS

On April 30, 2020, the Minnesota Department of Health completed a complaint investigation at St Benedicts Senior Community to determine if your facility was in compliance with Federal requirements related to the complaint. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567. Because corrective actions were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the April 30, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are St Benedicts Senior Community

Page 2

disputing those deficiencies, and (4) supporting documentation by fax or email to:

Kathleen Lucas, Unit Supervisor St. Cloud B Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: kathleen.lucas@state.mn.us Fax: (320) 223-7348

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

St Benedicts Senior Community may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at <u>https://qioprogram.org/</u>. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at <u>https://qioprogram.org/locate-your-qio</u>.

Sincerely,

Davente Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program

St Benedicts Senior Community

Page 3 Program Assurance Unit Health Regulation Division Telephone: 651-201-4118 Fax: 651-215-9697 Email: doug.larson@state.mn.us

cc: Licensing and Certification File

243390 P. WING C 04/30/202 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MUNRESOTA BOULEVARD SOUTHEAST ST BENEDICTS SENIOR COMMUNITY SUMMARY STATEMENT OF DEPICIENCIES, EACH DEPICIENCIES, CONTEXTORING INFORMATION PIE PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION OF CORRECTION PROVIDERS PLAN OF CORRECTION OF CORRECTION OF CORRECTION PROVIDERS PLAN OF CORRECTION OF CORRE		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY: STATE, ZIP CODE ST BENEDICTS SENIOR COMMUNITY STREET ADDRESS, CITY: STATE, ZIP CODE MAR DEPROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX CACAD BEFICIENCY MUST BE PRECEDED BY FULL TAG PREVIX MUST BE PRECEDED BY FULL TAG SUMMARY STATEMENT OF DEFICIENCIES F000 INITIAL COMMENTS F000 On 4/29/20 through 4/30/20, an abbreviated COMPL SUTTE 200 PROVIDER STATEMENT F000 On 4/29/20 through 4/30/20, an abbreviated F000 U1) to resident health and safety. An IJ at F678 F600 began on 4/24/20, when resided of the U for R1 on 4/30/20, and the absent pulse and respirations. The administrator and director of nursing (DON) were notified of the U for R1 on 4/30/20, at 100 p.m. The facility corrected the Li U on 4/29/20 prior to surveys are straining. The following complaints were found to be substantiated at F678. Kithough the provider had implemented corrective realing and prior to the correction.			245350				-
ST BENEDICTS SENIOR COMMUNITY 1810 MINHESOTA BOULTEAST SAINT CLOUD, MIN 5630 OR ACTOR SENIOR COMMUNITY PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REQUATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PREFIX (2ACH CORRECTIVE ACTION BCOMMATION) O PREFIX F 000 INITIAL COMMENTS F 000 Provide the approximate O PREFIX F 000 INITIAL COMMENTS F 000 F 000 On 4/29/20 through 4/30/20, an abbreviated survey was completed at your facility by the Minnesota Department of Health (MDH). The facility was found not to be in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. F 000 The survey resulted in an immediate jeopardy (U) to resident health and safety. An U at F678 began on 4/24/20, when resident (R1 had diled. The facility failed to ensure timely cardiopulmonary resuscitation (CPR) was delivered upon identifying R1 had absent pulse and respirations. The administrator and director of nursing (DON) were notified of the U for R1 on 4/30/20, related to the substantiated at F678. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustantiated at F678. Although the provider had inplemented corrective action prior to survey, immediate jeopardy was sustantiated at F678. Although no plan of correction. F 678 Cardio-Pulmonary Resuscitation (CPR) Survey as ustantiated the correction. F 678 Cardio-Pulmonary Resuscitation (CPR) Survey data corrective action prior to the correction. F				B. WING		04	/30/2020
ST BERDICTS SENCE COMMUNITY SAINT CLOUD, MN 56304 Image: Comparing the sentence of t	NAME OF F	PROVIDER OR SUPPLIER				ACT	
Mail Drog SumMark's stratulement of perciciencies December (Encoder 2000 and connection) December (Encoder 2000 and connection) December (Encoder 2000 and connection) Connection F 000 INITIAL COMMENTS F 000 F 000 INITIAL COMMENTS F 000 On 4/29/20 through 4/30/20, an abbreviated survey was completed at your facility by the Minimersota Department of Health (MDH). The facility was found not to be in compliance with requirements of 42 CFR part 443, Subpart B, and Requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (U) to resident health and safety. An U at F678 began on 4/24/20, when resident (R1) had bled. The facility date on survey one scotted on (CPR) was delivered upon identifying R1 had absent pulse and respirations. The administrator and director of nursing (DON) were notified of the U for R1 on 4/30/20, at 1:00 p.m. The facility corrected the LU on 4/29/20 prior to survey ors entering, and F678 is being issued at past non-compliance. In addition, an extended survey was completed 4/30/20, related to the substantand quality of care findings. The following complaints were found to be substantiated: H5450101C was substantiated at F678. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the correction. F 678 S/22/2 F 678 Carcio-Duinonary Resuscitation (CPR) F 678 S/22/2	ST BENE	DICTS SENIOR COM	IMUNITY			ASI	
Přečrá Tao IEACH DEPRICENCY MUST BE PRECEDED P FULL REGULATORY OR LSCIDENTIFYING INFORMATION) PRČIN TAO CROSS-REFERENCED TO THUR ADPROPRIATE COMMINICATION SHOULD BE CROSS-REFERENCED TO THUR ADPROPRIATE COMMINICATION SHOULD BE CROSS-REFERENCED TO THUR ADPROPRIATE COMMINICATION SHOULD BE DEFICIENCY F 000 INITIAL COMMENTS F 000 F 000 <td< td=""><td></td><td></td><td></td><td></td><td>SAINT CLOUD, MIN 56304</td><td></td><td></td></td<>					SAINT CLOUD, MIN 56304		
On 4/29/20 through 4/30/20, an abbreviated survey was completed at your facility by the Minnesota Department of Health (MDH). The facility was found not to be in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (U) to resident health and safety. An IJ at F678 began on 4/24/20, when resident (R1) had died. The facility failed to ensure timely cardiopulmonary resuscitation (CPR) was delivered upon identifying R1 had absent pulse and respirations. The administrator and director of nursing (DON) were notified of the IJ for R1 on 4/30/20, at 1:00 p.m. The facility corrected the IJ on 4/29/20 prior to surveyors entering, and F678 is being issued at past non-compliance. In addition, an extended survey was completed 4/30/20, related to the substandard quality of care findings. For8 The following complaints were found to be substantiated: H5450101C was substantiated at F678. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the correction. Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents. F 678 F 678 Cardio-Pulmonary Resuscitation (CPR) F 678 Star2/2 CFR(s): 483.24(a)(3) E102	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP	ULD BE	(X5) COMPLETION DATE
survey was completed at your facility by the Minnesota Department of Health (MDH). The facility was found not to be in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident thealth and safety. An IJ at F678 began on 4/24/20, when resident (R1) had died. The facility failed to ensure timely cardiopulmonary resuscitation (CPR) was delivered upon identifying R1 had absent pulse and respirations. The administrator and director of nursing (DON) were notified of the IJ for R1 on 4/30/20, at 1:00 p.m. The facility corrected the IJ on 4/29/20 prior to surveyors entering, and F678 is being issued at past non-compliance. In addition, an extended survey was completed 4/30/20, related to the substandard quality of care findings. The following complaints were found to be substantiated: H5450101C was substantiated at F678. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the correction. Although no plan of correction is required the facility acknowledge receipt of the electronic documents. F 678 CFR(s): 483.24(a)(3) F 678 CFR(s): 483.24(a)(3) F 678 CFR(s): 483.24(a)(3) MEMONY DIRECTOR'S OR PROVIDER/SUPPLER REPRESENTATIVES SIGNATURE THE MEMONY DIRECTOR'S OR PROVIDER/SUPPLER REPRESENTATIVES SIGNATURE 	F 000	INITIAL COMMEN	TS	F 0	00		
(IJ) to resident health and safety. An IJ at F678 began on 4/24/20, when resident (R1) had died. The facility failed to ensure timely cardiopulmonary resuscitation (CPR) was delivered upon identifying R1 had absent pulse and respirations. The administrator and director of nursing (DON) were notified of the IJ for R1 on 4/30/20, at 1:00 p.m. The facility corrected the IJ on 4/29/20 prior to survey ors entering, and F678 is being issued at past non-compliance. In addition, an extended survey was completed 4/30/20, related to the substandard quality of care findings. The following complaints were found to be substantiated: H5450101C was substantiated at F678. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the correction. Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents. F 678 Cardio-Pulmonary Resuscitation (CPR) SS=J CFR(s): 483.24(a)(3) F 678 EVENUENCEMENT (SOURDER SUPPLIER REPRESENTATIVE'S SIGNATURE) Tute (X6) DM1		survey was comple Minnesota Departr facility was found r requirements of 42	eted at your facility by the ment of Health (MDH). The not to be in compliance with 2 CFR Part 483, Subpart B,				
4/30/20, related to the substandard quality of care findings. The following complaints were found to be substantiated: H5450101C was substantiated at F678. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the correction. Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents. F 678 Cardio-Pulmonary Resuscitation (CPR) SS=J CFR(s): 483.24(a)(3)		(IJ) to resident hea began on 4/24/20, The facility failed to cardiopulmonary re delivered upon ide and respirations. of nursing (DON) v 4/30/20, at 1:00 p. on 4/29/20 prior to	Alth and safety. An IJ at F678 when resident (R1) had died. b ensure timely esuscitation (CPR) was ntifying R1 had absent pulse The administrator and director vere notified of the IJ for R1 on m. The facility corrected the IJ surveyors entering, and F678				
substantiated: H5450101C was substantiated at F678. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the correction. Although no plan of correction is required for a Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents. F 678 Cardio-Pulmonary Resuscitation (CPR) SS=J CFR(s): 483.24(a)(3) ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE		4/30/20, related to					
Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the correction. Image: Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents. Image: Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents. Image: F 678 Cardio-Pulmonary Resuscitation (CPR) F 678 Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) Image: F 678 Time factor is consistent in the factor is consiste			plaints were found to be				
finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents. 5/22/2 F 678 Cardio-Pulmonary Resuscitation (CPR) F 678 SS=J CFR(s): 483.24(a)(3) F 678 ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		Although the provi corrective action p	der had implemented rior to survey, immediate				
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		finding of past non facility acknowledg documents. Cardio-Pulmonary	-compliance, it is required the ge receipt of the electronic Resuscitation (CPR)	F 6	78		5/22/20
					דודו ה		
Electronically Signed 05/22/			DERISOPPLIER REPRESENTATIVE'S SIGI	NATURE	IIILE		05/22/202

Electronically Signed

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/27/2020

OMB NO. 0938-0391

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245350 B. WING 04/30/2020 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) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 678 Continued From page 1 F 678 §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced bv: Based on interview and document review, the Past noncompliance: no plan of facility failed to initiate timely cardio-pulmonary correction required. resuscitation (CPR) in accordance with resident wishes and physician orders for 1 of 3 residents (R1) reviewed for CPR. This deficient practice resulted in an immediate jeopardy (IJ) when R1 was found with absent pulse and respirations, timely CPR was not initiated, and R1 died. The IJ began on 4/24/20, when R1 was found with an absent pulse and respirations, timely CPR was not initiated, and R1 died. The administrator and director of nursing (DON) were made aware of the incident on 4/24/20, and immediately initiated corrective actions. The administrator and director of nursing (DON) were notified of the IJ on 4/30/20, at 1:00 p.m. The facility implemented corrective action on 4/29/20, prior to the onsite investigation, and the deficiency is being issued at past non-compliance. Findings include: R1's Admission Record printed 4/30/20, indicated R1's diagnoses included compromised pulmonary function, diabetes, blindness, chronic kidney disease, and traumatic brain injury.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 2 of 8

PRINTED: 05/27/2020

PRINTED: 05/27/2020 FORM APPROVED OMB NO. 0938-0391

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

			-			-	
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION		E SURVEY PLETED
		245250	B. WING				C
		245350	B. WING			04/3	30/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	810 MINNESOTA BOULEVARD SOUTHEAS	Г	
ST BENE	DICTS SENIOR COM	MUNITY		ç	SAINT CLOUD, MN 56304		
	0.000						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 APPROPE	BE	(X5) COMPLETION DATE
					DEFICIENCY		
F 678	R1's admission Car dated 3/29/20, indic impaired cognition. R1's Advance Direc 3/23/20, directed st into cardiac arrest of document was sign The Facility Investig 4/24/20, indicated r R1 with no pulse, n with no response. practical nurse (LPI passing. RN-A ask code status. RN-B checked R1's code confirmed as full co The medical directo discontinue efforts received. Although a delay of approxim facility interviewed RN-B was interview for the investigation education for all sta Response. During interview on was interviewed reg stated at approxima	cated R1 had moderately cated R1 had moderately ctive Consent Form dated caff to perform CPR if R1 went or respiratory arrest. The	F	678	DEFICIENCY)		
	stated at approxima RN-B came to RN- away. RN-A asked and RN-B did not k was. RN-A and RN paper charts were a (will allow all interve	ately 9:30 a.m. on 4/24/20,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00774

If continuation sheet Page 3 of 8

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245350 B. WING 04/30/2020 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) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 678 Continued From page 3 F 678 phone with LPN-A doing a telehealth rounding session and the physician directed to do ten compressions for R1 and check for a pulse, and if no response do not continue. RN-A stated about 9:45 a.m. they went to R1's room and performed ten compressions, R1 had no pulse, and efforts were halted. RN-A stated there was no code blue (an emergency situation announced in an institution in which a patient is in cardiopulmonary arrest, requiring a team of providers to rush to the specific location and begin immediate resuscitative efforts) called for R1. RN-A stated RN-B was taken off the floor, talked to by the director of nursing (DON), and has not been back to the unit. RN-A stated the facility started asking staff what they would do if they found an unresponsive person on 4/24/20. RN-A stated staff from the day shift received education and as the evening shift came in to work they received education on what to do when you would find an unresponsive person in the facility. RN-A stated you check the resident's code status in the paper chart or have someone look for you. RN-A stated staff had to sign a sheet that indicated they had read the policy and what the expectation of the facility was for an unresponsive person. During interview on 4/29/20, at 3:20 p.m. nursing assistant (NA)-A was interviewed regarding the passing of R1. NA-A stated that morning R1 was up for breakfast at 8:00 a.m. in the dining room. R1 ate breakfast and did not mention any discomfort. NA-A stated R1 was assisted to bed after breakfast, about 9:00 a.m. NA-A further stated later in the morning, unsure of the time, RN-B called over the walkie talkie that help was needed in R1's room. NA-A stated R1 was laying

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00774

If continuation sheet Page 4 of 8

PRINTED: 05/27/2020

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245350 B. WING 04/30/2020 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) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 678 Continued From page 4 F 678 on right side with a pillow behind the back. NA-A stated RN-B thought R1 had passed away. RN-B went to get the vital machine and there was no blood pressure, no oximetry (measure the oxygen level of the blood). NA-A stated R1 was gravish in color. NA-A stated NA-A went to get RN-A and RN-A was on a telephone conference. RN-B went to get someone else. NA-A never went back into R1's room until R1 was prepared for viewing by the family. On 4/29/20, at 3:59 p.m. the DON was interviewed and stated RN-A had come to see her after she had a missed call from RN-A. The DON went on to state that RN-A told her there was a problem, that R1 had coded, was a full code and CPR was not immediately initiated. The DON stated the administrator was also informed of the incident at this time. The DON stated they started the investigation immediately, obtained written statements from those involved, and that following interview and obtaining a written statement, RN-B was suspended. The DON stated they had initiated "whole house" education on how to response to an unresponsive resident, what they would do when a resident is found unresponsive, and what the expectation is. The DON stated staff working during the day shift on 4/24/20, were asked to read and sign they understood the facility process for a resident that is found unresponsive that included the following, to call for assistance and have someone check the code status for the resident and if a full code, staff would call a code blue and proceed with CPR. If the resident was DNR (do not resuscitate) then staff were to follow the process of expiration. The DON stated a code blue is called to get more staff to the

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 5 of 8

PRINTED: 05/27/2020

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245350 B. WING 04/30/2020 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) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 678 Continued From page 5 F 678 location quickly and for assistance. The DON stated the evening shift on 4/24/20, was educated on this same process as they came in to work and the rest of the staff continued to be educated when they came for their shift. The DON stated this education was completed by the nurse managers on the unit when the staff entered the facility. The DON stated, on the day of the incident, a code blue was not called for R1 and CPR should have been initiated. On 4/29/20, at 4:10 p.m. LPN-A was interviewed and stated on the day of the incident of 4/24/20, she was talking with the physician when RN-B came into the area and stated R1 was cool to the touch and had passed away. RN-B left the area to find RN-A. Then RN-A and RN-B came to the area and checked on R1's code status. R1's code status was listed as full code. LPN-A stated the physician told them to try CPR. LPN-A was not sure of the exact time. When asked about what she would do if a resident was found unresponsive, LPN-A stated it does not matter if the resident is cold you do CPR until called (time of death) by the physician. LPN-A stated our policy indicates if unresponsive, check the paper chart for code status, if full code, call code blue and start CPR. LPN-A stated others could call 911 while CPR compressions are started until emergency management system (EMS) would come and take over the compressions. During a telephone interview on 4/30/20, at 10:18 a.m. RN-B stated on 4/24/20, the day of the incident, RN-B entered R1's room at 9:35 a.m. to administer medication. R1 was in bed. RN-B stated R1 did not respond to the areeting from RN-B, that R1's eves were open, no blinking, and

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00774

If continuation sheet Page 6 of 8

PRINTED: 05/27/2020

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 245350 B. WING 04/30/2020 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) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 678 Continued From page 6 F 678 R1's color was gray. RN-B stated the covers were lowered and RN-B placed a hand on R1's chest to see if R1 was breathing and checked R1's right wrist for a pulse. R1's finger tips were a blue, purple color, and that R1's hands and arms were cool to the touch. RN-B stated she called over the walkie talkie for a NA to assist. RN-B went to get the vital machine and did a blood pressure (BP) on the right upper arm and there was no reading obtained. RN-B stated at 9:38 a.m. she went to RN-A's office and they were in a meeting and then talked to LPN-A about what the process was for residents that passed away. At 9:40 a.m. RN-A came out of the office and RN-B stated R1 had passed away. RN-A had asked what R1's code status was. RN-B stated that R1's code status was not checked and they both proceeded to the paper chart where R1 was determined to be a full code. The physician was on the phone and could hear the conversation and told them to do ten chest compressions and check for a pulse and if there was no pulse, to call it. RN-B stated this direction was followed and the time RN-B was 9:42 a.m. RN-B stated following R1's death, she had not done any charting of the incident. RN-B had not called a code blue for R1. RN-B stated, "I did not check [R1's] code status and I do not know why I did not check code status." RN-B stated RN-B had CPR certification and was current. RN-B stated she assumed R1 was a DNR/DNI (do not resuscitate/intubate). RN-B stated she was sent home while the investigation was pending. On 4/30/20, at 11:33 a.m. family member (FM)-A was interviewed and stated R1 was treated well and had no concerns that were shared about the facility. FM-A stated the facility called and stated

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00774

If continuation sheet Page 7 of 8

PRINTED: 05/27/2020

		AND HUMAN SERVICES				FORM	05/27/2020 APPROVED 0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				`́сомі	E SURVEY PLETED
		245350	B. WING	i			C 30/2020
	PROVIDER OR SUPPLIER	MUNITY		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1810 MINNESOTA BOULEVARD SOUTHEAS SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 678	R1 was found by th away. FM-A stated and that is why he p The facility impleme prevent recurrence facility started to ed staff and unlicensee Response for findin Staff are to immedia code status in the p resuscitate) no furth code, immediately if were trained prior to plan in place to retri- working. In addition were able to correct	e nurse and had passed the facility did not help R1	F	678			

The facility policy Code Blue Response, undated, indicated if a resident is witnessed to become unresponsive or is found unresponsive and is without a pulse or respiration, you must immediately call for assistance and check the paper chart to confirm the resident's code status preference. If the resident code status is indicated Do Not Resuscitate (DNR) no further intervention is required. If the resident has indicated a wish for Resuscitate/full code immediately initiate CPR.

FORM CMS-2567(02-99) Previous Versions Obsolete



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 15, 2020

Administrator St Benedicts Senior Community 1810 Minnesota Boulevard Southeast Saint Cloud, MN 56304

Re: State Nursing Home Licensing Orders Event ID: TET611

Dear Administrator:

The above facility was surveyed on April 29, 2020 through April 30, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

St Benedicts Senior Community May 15, 2020 Page 2

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Kathleen Lucas, Unit Supervisor St. Cloud B Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Midtown Square 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557 Email: kathleen.lucas@state.mn.us Phone: (320) 223-7343 Fax: (320) 223-7348

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Doverto Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health

St Benedicts Senior Community May 15, 2020 Page 3 Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4118 Fax: 651-215-9697 Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Minnesc	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00774	B. WING		04/3	; 0/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST BEN	EDICTS SENIOR COM	MUNITY	NESOTA BO OUD, MN 5	ULEVARD SOUTHEAST 6304		
(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
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre pursuant to a surve found that the defic herein are not corre not corrected shall	Minnesota Statute, section ction order has been issued by. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health.				
	corrected requires requirements of the number and MN Ru When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all a rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will sment of a fine even if the item uring the initial inspection was				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	Department's staff,	ΓS: h 4/30/20, surveyors of this visited the above provider prrection orders are issued.				
		ed in ePOC and therefore a uired at the bottom of the first				
Minnesota D	epartment of Health	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
Electron	ically Signed					05/22/20
STATE FOR	M		6899	IET611	If continuati	on sheet 1 of 10

If continuation sheet 1 of 10

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00774	B. WING			C 4/30/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ST BENE	EDICTS SENIOR COM	MUNITY	INESOTA BOL LOUD, MN 56	JLEVARD SOUTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE	
2 000	Continued From pa	ige 1	2 000				
	correction is require	567 form. Although no plan of ed, it is required that the e receipt of the electronic					
21830	MN St. Statute 144 Residents of HC Fa	.651 Subd. 10 Patients & ac.Bill of Rights	21830			4/30/20	
	Subd. 10. Particip notification of family	pation in planning treatment; y members.					
	in the planning of the includes the opport alternatives with inco- opportunity to requi- care conferences, a family member or or both. In the event the present, a family member or conferences.	Il have the right to participate heir health care. This right unity to discuss treatment and dividual caregivers, the est and participate in formal and the right to include a ther chosen representative or that the resident cannot be ember or other representative dent may be included in such					
	unconscious or con communicate, the f efforts as required t either a family men writing by the reside an emergency that	vho enters a facility is natose or is unable to acility shall make reasonable under paragraph (c) to notify nber or a person designated in ent as the person to contact in the resident has been lity. The facility shall allow the					
	family member to p planning, unless the to believe the resid directive to the com- has specified in wri family member inclu	articipate in treatment e facility knows or has reason ent has an effective advance trary or knows the resident ting that they do not want a uded in treatment planning. nily member but prior to					
	allowing a family m	ember to participate in the facility must make					

ROVIDER OR SUPPLIER	00774	B. WING			С
		D. WING			30/2020
DICTS SENIOR COM	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
	IMIINITY	INESOTA BOU LOUD, MN 563	ILEVARD SOUTHEAST 304		
	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF		(X5)
	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLET DATE
Continued From pa	age 2	21830			
•					
esident's health car	re decisions. For purposes of				
this paragraph, "reasonable efforts" include: (1) examining the personal effects of the					
,					
physician to whom					
	ne physician to whom the				
contact, the facility	shall attempt to identify family				
	Continued From pareasonable efforts, medical practice, to executed an advance esident's health car this paragraph, "rea- (1) examining the resident; (2) examining the resident in the pose (3) inquiring of a family member con- whether the residen directive and wheth physician to whom care; and (4) inquiring of the resident normally g whether the resident directive. If a facilitid designated emerger member to participa accordance with the liable to resident for that the notification emergency contact family member was patient's privacy rige (c) In making rea- family member or co contact, the facility members or a design examining the person and the medical rea- posession of the f to notify a family m emergency contact admission, the facility	 (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member or etaint's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact or the participation of the family member or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and 	Continued From page 221830reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility. If the facility is unable to notify a family member or designated emergency contact by the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact by the resident in the possession of the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and	Continued From page 2 21830 reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the medical records of the resident; (2) examining the medical records of the resident; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has a executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family members or a designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and	Continued From page 2 reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts' include: (1) examining the medical records of the resident; (2) examining of any emergency contact or family member contacted under this section whether the resident has a executed an advance directive and whether the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has a secuted an advance directive and whether the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has a advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 04/30/2020	
		00774	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
ST BENI	EDICTS SENIOR COM	MUNITY	INESOTA BO LOUD, MN 5	ULEVARD SOUTHEAST 6304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLET DATE
21830	the facility has been member or designal county social service enforcement agence identifying and notif designated emerge service agency or le that assists a facilit subdivision is not lia damages on the gro the family member participation of the or violated the patie This MN Requirement by: Based on interview facility failed to initia resuscitation (CPR wishes and physical (R1) reviewed for C resulted in an imment was found with abs timely CPR was no The IJ began on 4/2 with an absent puls CPR was not initiat administrator and d made aware of the immediately initiate administrator and d notified of the IJ on facility implemented	n unable to notify a family ated emergency contact. The ce agency and local law cy shall assist the facility in fying a family member or ency contact. A county social ocal law enforcement agency y in implementing this able to the resident for ounds that the notification of or emergency contact or the family member was improper ent's privacy rights. ent is not met as evidenced and document review, the ate timely cardio-pulmonary) in accordance with resident an orders for 1 of 3 residents CPR. This deficient practice ediate jeopardy (IJ) when R1 ent pulse and respirations, t initiated, and R1 died. 24/20, when R1 was found a corrective actions. The lirector of nursing (DON) were incident on 4/24/20, and d corrective actions. The lirector of nursing (DON) were 4/30/20, at 1:00 p.m. The d corrective action on 4/29/20, nvestigation, and the		Corrected.		

TET611

If continuation sheet 4 of 10

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00774	B. WING			04/30/2020		
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S					
ST BENE	EDICTS SENIOR COM	IMIINITY	NESOTA BOU LOUD, MN 56	ILEVARD SOUTHEAST 304				
(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 ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE		
21830	Continued From pa	age 4	21830					
	Findings include:	Findings include:						
	R1's diagnoses inc pulmonary function	cord printed 4/30/20, indicated luded compromised , diabetes, blindness, chronic d traumatic brain injury.	ł					
		re Area Assessment (CAA) cated R1 had moderately						
	3/23/20, directed st	ctive Consent Form dated taff to perform CPR if R1 went or respiratory arrest. The ned by R1.						
	4/24/20, indicated r R1 with no pulse, n with no response. practical nurse (LP passing. RN-A ask code status. RN-B checked R1's code confirmed as full co The medical directo discontinue efforts received. Although a delay of approxim facility interviewed RN-B was interview for the investigation	gation of alleged neglect dated registered nurse (RN)-B found to breathing, and eyes open RN-B notified licensed N)-A and RN-A of R1's revealed she had not status. R1's code status was ode. CPR was then initiated. or was notified and an order to and call the time of death was n CPR was initiated, there was nately eight minutes. The staff regarding the incident. wed and placed on suspension n. The facility initiated aff regarding the Code Blue						
	was interviewed re	n 4/29/20, at 1:38 p.m RN-A garding R1's passing and ately 9:30 a.m. on 4/24/20,						

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C		
		00774	B. WING			04/30/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE			
ST BENE	EDICTS SENIOR COM	IMIINITY	INESOTA BOU LOUD, MN 56	JLEVARD SOUTHEAST 304			
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21830	RN-B came to RN- away. RN-A asked and RN-B did not k was. RN-A and RN paper charts were a (will allow all interve heart started). The phone with LPN-A session and the ph compressions for F if no response do n about 9:45 a.m. the performed ten com and efforts were ha no code blue (an et in an institution in v cardiopulmonary an providers to rush to begin immediate re R1. RN-A stated R talked to by the dire has not been back facility started askin they found an unre RN-A stated staff fr education and as th	A and stated R1 had passed what R1's code status was now what R1's code status I-B went to the area where the and found R1 was a full code entions needed to get their physician was on speaker doing a telehealth rounding ysician directed to do ten R1 and check for a pulse, and ot continue. RN-A stated ey went to R1's room and pressions, R1 had no pulse, lted. RN-A stated there was mergency situation announced					
	you would find an u facility. RN-A state code status in the p look for you. RN-A sheet that indicated what the expectatio unresponsive perso During interview or assistant (NA)-A wa passing of R1. NA-	Inresponsive person in the d you check the resident's paper chart or have someone stated staff had to sign a d they had read the policy and on of the facility was for an					

linnesota Departi TATEMENT OF DEFICI ND PLAN OF CORREC	ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00774	B. WING			30/2020
AME OF PROVIDER O	R SUPPLIER	STREET	ADDRESS, CITY, S ⁻	TATE, ZIP CODE		
T BENEDICTS SE			NNESOTA BOU CLOUD, MN 56	JLEVARD SOUTHEAST 304		
(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF ((X5)
		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21830 Continue	d From pa	age 6	21830			
discomfo after brea stated lat RN-B cal needed ii on right s stated RI RN-B we was no b the oxyge was gray get RN-A conferen NA-A new was prep On 4/29// interview her after DON we was a pro code and The DON informed stated the obtained and that written st DON state education unrespor a resider	rt. NA-A s akfast, abo er in the n led over the n R1's roo ide with a N-B though nt to get the lood press en level of ish in colo and RN-A ce. RN-B ver went b ared for vi 20, at 3:59 ed and sta she had a ton to sta oblem, that CPR was I stated the of the inci- ey started written sta following i atement, I is found on how the sive resid t is found on is. The e day shift	nd did not mention any stated R1 was assisted to bed but 9:00 a.m. NA-A further norning, unsure of the time, ne walkie talkie that help was m. NA-A stated R1 was layin pillow behind the back. NA-A ht R1 had passed away. ne vital machine and there sure, no oximetry (measure the blood). NA-A stated R1 r. NA-A stated NA-A went to A was on a telephone went to get someone else. ack into R1's room until R1 iewing by the family. D p.m. the DON was ated RN-A had come to see missed call from RN-A. The ate that RN-A told her there t R1 had coded, was a full s not immediately initiated. e administrator was also ident at this time. The DON the investigation immediately atements from those involved interview and obtaining a RN-B was suspended. The ad initiated "whole house" o response to an ent, what they would do wher unresponsive, and what the DON stated staff working c on 4/24/20, were asked to	νg Α			

TATEMENT	a Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00774	B. WING			C 30/2020
AME OF PF	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
T BENED	DICTS SENIOR COM	MUNITY	NESOTA BOU LOUD, MN 56	ILEVARD SOUTHEAST 304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
	blue and proceed w DNR (do not resusc the process of expir code blue is called location quickly and stated the evening educated on this sat to work and the res educated when the DON stated this ed nurse managers on entered the facility. of the incident, a co and CPR should ha On 4/29/20, at 4:10 and stated on the d she was talking with came into the area touch and had pass to find RN-A. Then area and checked of code status was list the physician told th not sure of the exact what she would do unresponsive, LPN the resident is cold of death) by the phy policy indicates if un chart for code status and start CPR. LPI 911 while CPR com emergency manage come and take ove	I code, staff would call a code vith CPR. If the resident was citate) then staff were to follow ration. The DON stated a to get more staff to the d for assistance. The DON shift on 4/24/20, was ame process as they came in t of the staff continued to be y came for their shift. The ucation was completed by the the unit when the staff The DON stated, on the day ode blue was not called for R1				

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00774	B. WING			C 30/2020
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE. ZIP CODE		
		1810 MIN		ILEVARD SOUTHEAST		
I BENE	DICTS SENIOR COM	IMUNITY SAINT C	LOUD, MN 56	304		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF ((X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21830	Continued From pa	ige 8	21830			
	incident, RN-B ente	ered R1's room at 9:35 a.m. to				
		ion. R1 was in bed. RN-B				
		espond to the greeting from				
		es were open, no blinking, and				
		y. RN-B stated the covers RN-B placed a hand on R1's				
		vas breathing and checked				
		a pulse. R1's finger tips were				
	a blue, purple color	, and that R1's hands and				
		he touch. RN-B stated she				
F		kie talkie for a NA to assist.				
		ne vital machine and did a				
) on the right upper arm and ng obtained. RN-B stated at				
		to RN-A's office and they				
		and then talked to LPN-A				
		cess was for residents that				
		:40 a.m. RN-A came out of the	•			
		ated R1 had passed away.				
		hat R1's code status was.				
		1's code status was not both proceeded to the paper				
		s determined to be a full code.				
		on the phone and could hear				
		nd told them to do ten chest				
		check for a pulse and if there				
		II it. RN-B stated this direction				
		ne time RN-B was 9:42 a.m.				
		ing R1's death, she had not of the incident. RN-B had not				
		for R1. RN-B stated, "I did not	+			
		status and I do not know why I				
		status." RN-B stated RN-B				
	had CPR certification	on and was current. RN-B				
		d R1 was a DNR/DNI (do not				
		e). RN-B stated she was sent estigation was pending.				
	On 4/30/20, at 11:3					

		(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:			
		00774	B. WING			C 30/2020
AME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
	EDICTS SENIOR COM	IMIINITY		ILEVARD SOUTHEAST		
			LOUD, MN 56			
X4) ID PREFIX TAG	(EACH DEFICIENC)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC)	ACTION SHOULD BE COMPLET TO THE APPROPRIATE DATE	
21830	Continued From page 9		21830			
	Continued From page 9 was interviewed and stated R1 was treated well and had no concerns that were shared about the facility. FM-A stated the facility called and stated R1 was found by the nurse and had passed away. FM-A stated the facility did not help R1 and that is why he passed away. The facility implemented corrective action to prevent recurrence by 4/29/20. On 4/24/20, the facility started to educate all licensed nursing staff and unlicensed staff on the Code Blue Response for finding a resident unresponsive. Staff are to immediately check the resident's code status in the paper chart. If DNR, (do not resuscitate) no further action is required. If full code, immediately initiate CPR. 95% of staff were trained prior to survey on 4/29/20, with a plan in place to retrain the remaining staff prior to working. In addition, staff were interviewed and were able to correctly verbalize understanding of the established CPR policy and procedure. The facility policy Code Blue Response, undated, indicated if a resident is witnessed to become unresponsive or is found unresponsive and is without a pulse or respiration, you must immediately call for assistance and check the paper chart to confirm the resident's code status preference. If the resident code status is indicated a wish for Resuscitate (DNR) no further intervention is required. If the resident has indicated a wish for Resuscitate/full code immediately initiate CPR.					