Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 27, 2023

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

RE: CCN: 245501
Cycle Start Date: January 5, 2023

Dear Administrator:

On January 26, 2023, we notified you a remedy was imposed. On March 22, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 17, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 5, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 20, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 5, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 17, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

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April 27, 2023

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

Re: Reinspection Results
Event ID: O8VD12 and B02I12

Dear Administrator:

On February 21, 2023 and February 22, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on January 5, 2023 and January 18, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 26, 2023

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

RE: CCN: 245501
Cycle Start Date: January 5, 2023

Dear Administrator:

On January 20, 2023, we informed you that we may impose enforcement remedies.

On January 18, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Directed plan of correction, Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 5, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 5, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 5, 2023.

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

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

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 5, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Benedictine Living Community will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 5, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 5, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 01/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/18/23, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H55017522C (MN00090067), with a deficiency cited at F880 and F888. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		2/10/23

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

Electronically Signed | 02/02/2023

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

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F 880	Continued From page 1 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 2 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, and interview the facility failed implement measures to prevent the spread of infection when the facility failed to ensure personal protective equipment (PPE) was discarded prior to leaving resident rooms. This had the potential to affect all 53 residents who resided in the facility. Finding include: R1's COVID test results dated 1/11/23, indicated R1 had a positive COVID-19 test. R2's progress notes dated 1/16/22, indicated R2 had positive rapid Covid test. R3's record review dated 1/14/23, indicated R3 had an active COVID infection. On 1/18/23, at 9:20 a.m. outside of R3's room on top of a bedside table was N95 masks, disinfectant wipes, face shields, hand sanitizer, gowns and gloves. A sign on R3's door with pictures indicated eye protection, gown, N95	F 880	F880 E This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. All residents have the potential to be affected by this deficient practice. There are no current residents in isolation at the community as of 2.2.23. A Root Cause Analysis (RCA) was completed by an interdisciplinary team. See attached RCA The Policy/procedure regarding PPE usage was reviewed and revised to	

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F 880	Continued From page 3 masks, gloves, and isolation until 1/25/23. On 1/18/23 at 9:31 a.m. outside of R2's room observed a beside table was N95 masks, disinfectant wipes, face shields, hand sanitizer, gowns and gloves. A sign on R2's door with pictures indicated eye protection, gown, N95 masks, gloves, and isolation until 1/26/23. On 1/18/23 at 9:32 a.m. outside of R1's room observed a cart with PPE and contained N95 masks, disinfectant wipes, face shields, hand sanitizer, gowns and gloves. A sign on R1's door with pictures indicated eye protection, gown, N95 masks, gloves, and observed an uncovered garbage next to the PPE isolation cart. On 1/18/23, at 9:51 a.m. during an interview and observation nursing assistant (NA)-A donned a gown, N-95 mask, gloves, and eye protection and entered R3's room. At 10:02 a.m. observed NA-A exit R3's room walk across the hall and removed PPE that included gown, gloves, N-95 mask, and eye protection and discarded contaminated gown into a covered receptacle across the hall from R3's room. NA-A indicated R3 was COVID positive, and further confirmed PPE was removed outside of the R3's room because a garbage was not located inside of R3's room to place the contaminated PPE. NA-A confirmed the PPE was expected to be removed and discarded prior to exit of a resident's room who was on isolation. On 1/18/23, at 10:07 a.m. during an interview NA-B indicated R1, R2, and R3 were COVID-19 positive and staff were required to wear PPE prior to entrance of the rooms. NA-B confirmed a garbage was not available inside R1, R2 or R3's rooms to place the contaminated PPE prior to the	F 880	include proper doffing and discarding of PPE. See Attached policy update The IP RN will educate appropriate staff on the proper doffing and discarding of PPE on or before 2/10/23. The IP RN will monitor and conduct audits on proper PPE usage during outbreaks or as needed. See attachments When the facility would have a resident in isolation, we would then audit this practice 3x a week during that isolation period for those residents. We would continue to conduct these audits for a timeframe of 3 weeks or as deemed necessary through QC review for continued compliance. Staff have been assigned appropriate Infection Prevention Educare modules as on-going education and will be completed by 2/10/23 for all working staff. The IP RN will conduct PPE competency training on all staff and will document training and all will have this completed by 2/10/23. Substantial compliance will be achieved by February 10, 2023.	

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F 880	Continued From page 4 exit of the rooms. During observation and interview on 1/18/23, at 10:12 a.m. observed registered nurse (RN)-A exit R1's room and removed contaminated gown and placed the gown in an uncovered garbage outside of R1's room next to a cart with unused PPE (gowns, gloves, N95 masks). Located directly to the left side of the clean PPE supply cart a receptacle for contaminated PPE was observed. R1's room failed to have a garbage for staff to remove contaminated PPE prior to exiting the room. RN-B indicated R1 and R2 shared a garbage for contaminated PPE that was located outside of R1's room and staff had to walk across the hall to place R2's contaminated PPE in the garbage. RN-A confirmed contaminated PPE was expected to be removed prior to the exit of a residents room and the garbage was expected to be covered. RN-A indicated the facility did not provide a garbage in the resident's rooms to discard PPE. On 1/18/23, at 10:14 during an interview the infection prevention registered nurse, (RN)-B and the nurse manager, RN-C verified R1, R2, and R3 were in isolation due to COVID-19. RN-B and R-C further confirmed staff should not exit resident's rooms to discard the gowns. RN-B indicated staff received training on donning and doffing PPE. RN-B stated staff were taught to take all PPE off inside the room and stated staff were expected to take off PPE prior to exiting the resident's room. RN-B and RN-C stated the garbage's to dispose of PPE were expected in the residents room not outside the resident's room. RN-B and RN-C confirmed garbage receptacles were not located inside of resident's room to allow staff to discard of PPE prior to the exit.	F 880		

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F 880	Continued From page 5 Facility policy titled COVID-19 Policy Manual dated 2/7/20, indicated: Symptomatic and Positive Residents IP Practices - Stand, contact, and droplet precautions - Restrict resident with respiratory symptoms to his or her room - PPE HCP caring for residents with suspected or confirmed COVID-10 should use full PPE (gowns, gloves, eye protection and a NIOSH-approved N95 or equivalent or higher level respirator) The policy failed to indicate removal of PPE.	F 880		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners;	F 888		2/8/23

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F 888	Continued From page 6 (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;	F 888		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245501	A. BUILDING _____ B. WING _____	C 01/18/2023

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

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F 888	Continued From page 7 (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and	F 888		

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F 888	Continued From page 8 secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 71 staff members, including both direct and non-direct care staff, were vaccinated with a complete primary series of COVID-19 vaccine and/or had an approved or pending exemption on record. This resulted in a vaccination rate of 98.6% and had potential to affect all 53 residents in the facility. Findings include: The Centers for Medicare and Medicaid (CMS) QSO-23-02-ALL, dated 10/26/22, identified the revised guidance for staff vaccination requirements. The QSO outlined the requirement	F 888	F888 D This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. DA-A has had second vaccine and is in	

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F 888	Continued From page 9 for full staff vaccination had been enforced since February 2022, and listed a section labeled, "Vaccination Enforcement," which outlined, "CMS expects all providers' and suppliers' staff to have received the appropriate number of doses of the primary vaccine series unless exempted as required by law, or delayed as recommended by the CDC [Centers for Disease Control]. Facility staff vaccination rates under 100% constitute noncompliance under the rule." On 1/18/23, evidence of staff vaccinations was requested. A COVID-19 Staff Vaccination Status dated 1/18/23, provided by the administrator indicated, dietary aide (DA)-A was partially vaccinated. DA-A's document titled COVID-19 associate tracking dated 9/24/22, indicated DA-A declined the COVID-19 vaccination. DA-A's document titled Minnesota Immunization Information Connection printed 1/18/23, identified DA-A's name, date of birth, and administered vaccine doses, and identified only a single dose of the Pfizer vaccine was given on 10/6/22. No additional doses were recorded. There was no additional information presented on DA-A primary vaccination series despite the first dose being administered 10/6/22. On 1/18/23, at 12:45 p.m. during an interview registered nurse (RN)-B indicated she was the infection prevention (IP) nurse at the facility. RN-A indicated DA-A was a minor and the facility required parental consent for vaccinations at the facility, and stated DA-A had received the first COVID vaccination and was aware DA-A had not	F 888	compliance with policy. All new employees are given vaccination and exemption requirements upon general orientation. Employee vaccination/exemption status is monitored by the Human Resources Manager via the People Development System-Vista. The PDS system has the ability to run reports to assure all employees are in compliance with vaccinations/exemptions. Employees who have not been vaccinated, or do not have an approved exemption on file will be removed from the work schedule until vaccines given or the employee has an approved exemption on file. Human Resource Manager will monitor compliance and report during our monthly QAC meetings.	

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F 888	Continued From page 10	F 888		

completed the second shot of the series. RN-B indicated she would expect the employee to have been removed from the schedule if not vaccinated .

During an interview on 1/18/23, at 2:08 p.m. the administrator indicated the facility had one staff member, DA-A, who had not completed the second COVID-19 vaccine yet. The administrator indicated DA-A was a minor and required parental consent, and further indicated reminders had been sent to DA-A to fill out exemption or obtain the second COVID vaccination. When asked about DA-A's declination of the COVID-19 vaccination on 9/24/22, the administrator indicated DA-A was given paperwork to fill out an exemption and then on 10/6/22, DA-A received the first shot of the series. The administrator further indicated staff were expected to be removed from the schedule and not work, if the COVID vaccine series was not complete, however the facility had been short staffed in the culinary department and needed DA-A assistance with culinary.

On 1/18/23, at 3:25 p.m. a phone call was made to DA-A with no answer.

Review of DA-A's work schedule dated 12/22/22-1/18/23, indicated DA-A worked: 1/17/23, 1/15/23, 1/14/23, 1/10/23, 1/6/23, 1/5/23, 1/3/23, 1/1/23, 12/29/22, 1/27/22, 1/25/22, 12/23/22, and 12/22/22.

Document titled CMS Vaccine Mandate Manual dated 1/6/22, indicated:
-The CMS vaccine mandate requires that SNF staff must either (a) complete the primary vaccination series; (b) be granted an exemption

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F 888	Continued From page 11 to the vaccine requirement; or (c)be identified as needing a temporary delay in vaccination as recommend by the CDC due to clinical precautions and considerations. -All associates providing services for the SNF are subject to the CMS vaccine mandate expect those who work remotely 100% of the time. -Associates may seek a religious or medical exemption to the vaccine requirement via the exemption process. -The CMS vaccine mandate applies to minors. The minor may either receive the vaccine or seek and exemption. Parental consent is generally required for a provider to administer the vaccine, but that is only the community's concern if the community is administering the vaccine; parental consent is not required for an exemption request. -30 day new hire exception: an new SNF hire who receives one dose of a two dose vaccine series has a 30 day grace period to become fully vaccine. -Associates who fail to comply with the vaccine mandate may be subject to involuntary termination	F 888		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 26, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: B02I11

Dear Administrator:

The above facility was surveyed on January 18, 2023 through January 18, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00399	A. BUILDING: _____ B. WING _____	C 01/18/2023

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BENEDICTINE LIVING COMMUNITY	1907 KLEIN STREET ST PETER, MN 56082

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/18/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H55017522C (MN00090067), with a licensing order issued at 1385 and 1390. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 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.	2 000		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, and interview the facility failed implement measures to prevent the spread of infection when the facility failed to ensure personal protective equipment (PPE) was discarded prior to leaving resident rooms. This had the potential to affect all 53 residents who resided in the facility. Finding include: R1's COVID test results dated 1/11/23, indicated R1 had a positive COVID-19 test. R2's progress notes dated 1/16/22, indicated R2 had positive rapid Covid test. R3's record review dated 1/14/23, indicated R3 had an active COVID infection. On 1/18/23, at 9:20 a.m. outside of R3's room on	21385	Corrected	2/10/23

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21385	Continued From page 3 top of a bedside table was N95 masks, disinfectant wipes, face shields, hand sanitizer, gowns and gloves. A sign on R3's door with pictures indicated eye protection, gown, N95 masks, gloves, and isolation until 1/25/23. On 1/18/23 at 9:31 a.m. outside of R2's room observed a beside table was N95 masks, disinfectant wipes, face shields, hand sanitizer, gowns and gloves. A sign on R2's door with pictures indicated eye protection, gown, N95 masks, gloves, and isolation until 1/26/23. On 1/18/23 at 9:32 a.m. outside of R1's room observed a cart with PPE and contained N95 masks, disinfectant wipes, face shields, hand sanitizer, gowns and gloves. A sign on R1's door with pictures indicated eye protection, gown, N95 masks, gloves, and observed an uncovered garbage next to the PPE isolation cart. On 1/18/23, at 9:51 a.m. during an interview and observation nursing assistant (NA)-A donned a gown, N-95 mask, gloves, and eye protection and entered R3's room. At 10:02 a.m. observed NA-A exit R3's room walk across the hall and removed PPE that included gown, gloves, N-95 mask, and eye protection and discarded contaminated gown into a covered receptacle across the hall from R3's room. NA-A indicated R3 was COVID positive, and further confirmed PPE was removed outside of the R3's room because a garbage was not located inside of R3's room to place the contaminated PPE. NA-A confirmed the PPE was expected to be removed and discarded prior to exit of a resident's room who was on isolation. On 1/18/23, at 10:07 a.m. during an interview NA-B indicated R1, R2, and R3 were COVID-19 positive and staff were required to wear PPE prior	21385		

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21385	Continued From page 4 to entrance of the rooms. NA-B confirmed a garbage was not available inside R1, R2 or R3's rooms to place the contaminated PPE prior to the exit of the rooms. During observation and interview on 1/18/23, at 10:12 a.m. observed registered nurse (RN)-A exit R1's room and removed contaminated gown and placed the gown in an uncovered garbage outside of R1's room next to a cart with unused PPE (gowns, gloves, N95 masks). Located directly to the left side of the clean PPE supply cart a receptacle for contaminated PPE was observed. R1's room failed to have a garbage for staff to remove contaminated PPE prior to exiting the room. RN-B indicated R1 and R2 shared a garbage for contaminated PPE that was located outside of R1's room and staff had to walk across the hall to place R2's contaminated PPE in the garbage. RN-A confirmed contaminated PPE was expected to be removed prior to the exit of a residents room and the garbage was expected to be covered. RN-A indicated the facility did not provide a garbage in the resident's rooms to discard PPE. On 1/18/23, at 10:14 during an interview the infection prevention registered nurse, (RN)-B and the nurse manager, RN-C verified R1, R2, and R3 were in isolation due to COVID-19. RN-B and R-C further confirmed staff should not exit resident's rooms to discard the gowns. RN-B indicated staff received training on donning and doffing PPE. RN-B stated staff were taught to take all PPE off inside the room and stated staff were expected to take off PPE prior to exiting the resident's room. RN-B and RN-C stated the garbage's to dispose of PPE were expected in the residents room not outside the resident's room. RN-B and RN-C confirmed garbage receptacles	21385		

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21385	Continued From page 5 were not located inside of resident's room to allow staff to discard of PPE prior to the exit. Facility policy titled COVID-19 Policy Manual dated 2/7/20, indicated: Symptomatic and Positive Residents IP Practices - Stand, contact, and droplet precautions - Restrict resident with respiratory symptoms to his or her room - PPE HCP caring for residents with suspected or confirmed COVID-10 should use full PPE (gowns, gloves, eye protection and a NIOSH-approved N95 or equivalent or higher level respirator) The policy failed to indicate removal of PPE. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all staff were aware of doffing of PPE use. The DON or designee could audit the appropriate discarding of PPE and educate all staff on the requirements. The Director of Nursing or 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 (21) days.	21385		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data	21390		2/8/23

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	00399	A. BUILDING: _____ B. WING _____	C 01/18/2023

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

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21390	Continued From page 6 collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 71 staff members, including both direct and non-direct care staff, were vaccinated with a complete primary series of COVID-19 vaccine and/or had an approved or pending exemption on record. This resulted in a vaccination rate of 98.6% and had potential to affect all 53 residents in the facility. Findings include: The Centers for Medicare and Medicaid (CMS)	21390	Corrected	

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21390	Continued From page 7 QSO-23-02-ALL, dated 10/26/22, identified the revised guidance for staff vaccination requirements. The QSO outlined the requirement for full staff vaccination had been enforced since February 2022, and listed a section labeled, "Vaccination Enforcement," which outlined, "CMS expects all providers' and suppliers' staff to have received the appropriate number of doses of the primary vaccine series unless exempted as required by law, or delayed as recommended by the CDC [Centers for Disease Control]. Facility staff vaccination rates under 100% constitute noncompliance under the rule." On 1/18/23, evidence of staff vaccinations was requested. A COVID-19 Staff Vaccination Status dated 1/18/23, provided by the administrator indicated, dietary aide (DA)-A was partially vaccinated. DA-A's document titled COVID-19 associate tracking dated 9/24/22, indicated DA-A declined the COVID-19 vaccination. DA-A's document titled Minnesota Immunization Information Connection printed 1/18/23, identified DA-A's name, date of birth, and administered vaccine doses, and identified only a single dose of the Pfizer vaccine was given on 10/6/22. No additional doses were recorded. There was no additional information presented on DA-A primary vaccination series despite the first dose being administered 10/6/22. On 1/18/23, at 12:45 p.m. during an interview registered nurse (RN)-B indicated she was the infection prevention (IP) nurse at the facility. RN-A indicated DA-A was a minor and the facility required parental consent for vaccinations at the	21390		

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21390	Continued From page 8 facility, and stated DA-A had received the first COVID vaccination and was aware DA-A had not completed the second shot of the series. RN-B indicated she would expect the employee to have been removed from the schedule if not vaccinated . During an interview on 1/18/23, at 2:08 p.m. the administrator indicated the facility had one staff member, DA-A, who had not completed the second COVID-19 vaccine yet. The administrator indicated DA-A was a minor and required parental consent, and further indicated reminders had been sent to DA-A to fill out exemption or obtain the second COVID vaccination. When asked about DA-A's declination of the COVID-19 vaccination on 9/24/22, the administrator indicated DA-A was given paperwork to fill out an exemption and then on 10/6/22, DA-A received the first shot of the series. The administrator further indicated staff were expected to be removed from the schedule and not work, if the COVID vaccine series was not complete, however the facility had been short staffed in the culinary department and needed DA-A assistance with culinary. On 1/18/23, at 3:25 p.m. a phone call was made to DA-A with no answer. Review of DA-A's work schedule dated 12/22/22-1/18/23, indicated DA-A worked: 1/17/23, 1/15/23, 1/14/23, 1/10/23, 1/6/23, 1/5/23, 1/3/23, 1/1/23, 12/29/22, 1/27/22, 1/25/22, 12/23/22, and 12/22/22. Document titled CMS Vaccine Mandate Manual dated 1/6/22, indicated: -The CMS vaccine mandate requires that SNF staff must either (a) complete the primary	21390		

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21390	Continued From page 9 vaccination series; (b) be granted an exemption to the vaccine requirement; or (c)be identified as needing a temporary delay in vaccination as recommend by the CDC due to clinical precautions and considerations. -All associates providing services for the SNF are subject to the CMS vaccine mandate expect those who work remotely 100% of the time. -Associates may seek a religious or medical exemption to the vaccine requirement via the exemption process. -The CMS vaccine mandate applies to minors. The minor may either receive the vaccine or seek and exemption. Parental consent is generally required for a provider to administer the vaccine, but that is only the community's concern if the community is administering the vaccine; parental consent is not required for an exemption request. -30 day new hire exception: an new SNF hire who receives one dose of a two dose vaccine series has a 30 day grace period to become fully vaccine. -Associates who fail to comply with the vaccine mandate may be subject to involuntary termination SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could audit COVID-19 vaccine compliance for vaccinations and mitigation of COVID-19 for non-vaccinated employees. The DON or designee could report findings of the audits to the quality assurance committee for follow up to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		