DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 17, 2022

CMS Certification Number (CCN): 245350

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective August 1, 2022 the above facility is certified for:

174 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 174 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 17, 2022

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

RE: CCN: 245350
Cycle Start Date: June 16, 2022

Dear Administrator:

On August 9, 2022, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 6, 2022

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

RE: CCN: 245350
Cycle Start Date: June 16, 2022

Dear Administrator:

On June 16, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by September 16, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 16, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245350	A. BUILDING _____ B. WING _____	C 06/16/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On June 13-16, 2022, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On June 13-16, 2022, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. 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 H5350160C (MN81317), H5350162C (MN82559) and H53502267C (MN83597), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED: H5350155C(MN79643), H5350156C (MN79733), H5350157C (MN74984), H5350158C (MN81234), H5350159C (MN81257), H5350161C (MN81588), and H53502268C (MN83198). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are	F 000		

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

Electronically Signed | 07/15/2022

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 000	Continued From page 1 enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		8/1/22

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F 609	Continued From page 2 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and record review the facility failed to report an allegation of abuse to the State Survey Agency (SSA) for 1 of 7 residents (R69) reviewed for reporting abuse. Findings include: Review of R69's admission Minimum Data Set (MDS) indicated R69 was cognitively intact and required extensive assistance of two staff for bed mobility and transfers. A Grievance/Complaint Form, dated 01/16/22, indicated a family member of R69 reported a staff member (NA-C) ". . .was touching him [R69] where she shouldn't. . ." and was involved in altercation with R69, in which NA-C grabbed R69's neck call light and threw the call light at the resident. During an interview on 06/13/22, at 1:15 p.m. R69 stated NA-C grabbed his neck call light and threw it at him. R69 reported the incident to the facility and it was investigated. During an interview on 06/15/22, at 8:12 a.m. R69 stated NA-C did not touch him sexually. R69 demonstrated how NA-C grabbed the call light pendant and threw it at him. R69 stated he had never experienced anything like this before or since and felt like he might need to protect himself. During an interview on 06/16/22, at 8:31 a.m. Clinical Manager (CM)-B stated when an	F 609	On June 13-16, 2022, MDH Survey Team reviewed a grievance dated 1/16/2022. Leadership team at the time of the grievance concluded that grievance did not warrant a VA filed report. At the time of the survey, the Director of Nursing, who was hired on June 6, 2022, was interviewed by the surveyors regarding the grievance. The Director of Nursing stated that she would have filed a VA at the time of the grievance due to inconsistency in the interviews of R96 and staff. This was corrected for R96 through further re-review of the grievance and a VA filed on 7/18/2022 as part of our corrective action plan. The facility will identify other residents having the potential to be affected by this deficient practice of the Vulnerable Adults □ Abuse Prevention Policy- Long Term Care #9859864 was reviewed by St. Benedict□s Community Leaders and direct resident care employees on June 17 □ 20, 2022. In review of the grievance filed on 1/16/2022, discussion with employees to demonstrate clarity and understanding of policy. Moving forward, new employee orientation will include training on the policy by Education Staff. Unit Nursing Supervisors and Unit Social workers will round at a minimum of once a day with staff and residents to identify any concerns in patient care with documentation of visiting with residents in the patient□s health record. On July 11,	

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F 609	Continued From page 3 allegation of abuse occurred, the staff were to report it to the State Survey Agency (SSA) and begin an investigation. CM-B stated she gathered information and then called Social Worker (SW)-B and inquired if the allegations should be reported to the SSA. CM-B stated R69 provided conflicting information. Therefore, SW-B directed CM-B not to report to the SSA. During an interview on 06/16/22, at 9:14 a.m. SW-B confirmed the facility staff were mandated reporters and she assisted with abuse investigations. SW-B stated CM-B was the one who began the investigation of R69's allegations. SW-B stated the CM-B reported R69 had inconsistencies with his allegations. SW-B stated there was a short period of time (within two hours) in which the facility could begin their investigation of an allegation and interviews were collected immediately and the decision was made there was no abuse. During an interview on 06/16/22 at 9:43 a.m. the Director of Nursing (DON) stated her expectations was to notify the SSA immediately. The DON sated it was not up to the facility to make the determination if abuse occurred or not. Review of a policy provided by the facility titled "Vulnerable Adults-Abuse Prevention Policy-Long Term Care," dated 07/21, indicated it is the responsibility of the Long Term Care Facilities to ensure that all alleged violations involving abuse, neglect, injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation is made, if the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause	F 609	2022, it was determined to promote consistency of practice in understanding and following the Vulnerable Adult Abuse and Reporting Policy, an algorithm of the process will be developed for training and education for all direct care employees, Unit Nursing Supervisors, and new employees during onboarding by Regional Education Department and Director of Nursing. Mandatory training will be conducted using scenario-based learning to all direct care employees and Unit Nursing Leaders to validate understanding and competency of algorithm of the Vulnerable Adults □ Abuse Prevention Policy □ Long Term Care to be completed by August 1, 2022, under the direction of Regional Educator Senior Services and Director of Nursing to achieve compliance by August 1, 2022.	

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F 609	Continued From page 4 the allegation do not involve abuse and do not result in serious bodily injury, the administrator of the facility and to other officials. . .including to the State Survey Agency. . . Specific measures are taken to ensure a safe living environment for the residents.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and recored review the facility failed to protect the residents when NA-C was not immediately removed from the facility after allegations of abuse. Findings include: R69's admission Minimum Data Set (MDS) indicated R69 was cognitively intact and required	F 610	On June 13-16, 2022, MDH Survey Team reviewed a grievance dated 1/16/2022. Leadership team at the time of the grievance concluded that grievance did not warrant a VA filed report. At the time of the survey, the Director of Nursing, who was hired on June 6, 2022, was interviewed by the surveyors regarding the grievance. The Director of Nursing stated	8/1/22

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F 610	Continued From page 5 extensive assistance of two staff for bed mobility and transfers. A Grievance/Complaint Form dated 01/16/22, revealed a family member accused NA-C of being sexually inappropriate with R69 and took a hold of his pendant call light and threw it at R69. During an interview on 06/15/22, at 12:18 p.m. NA-C confirmed she had previously worked with R69 and was aware of the allegations. NA-C denied the allegations. NA-C stated she was interviewed by Clinical Manager (CM)-B, removed from the floor and reassigned to another unit after the allegations were made. NA-C stated she was surprised that she was not immediately suspended and placed on leave. During an interview on 06/16/22, at 9:14 a.m. Social Worker (SW)-B stated she was the official grievance manager for the facility. SW-B stated she did not know if NA-C was immediately removed from the facility after the allegation was made. During an interview on 06/16/22, at 2:37 p.m. CM-B stated she was not permitted to suspend a staff member. She reassigned NA-C to a different unit. During an interview on 06/16/22, at 2:49 p.m. the Director of Nursing (DON) stated she would remove the accused staff member immediately until the investigation was completed and a determination could be made. Review of facility's Vulnerable Adults-Abuse Prevention Policy-Long Term Care policy dated 07/21, indicated "Complete an internal	F 610	that she would have filed a VA at the time of the grievance due to inconsistency in the interviews of R96 and staff. This was corrected for R96 through further re-review of the grievance and a VA filed on 7/18/2022 as part of our corrective action plan. The facility will identify other residents having the potential to be affected by this deficient practice of the Vulnerable Adults □ Abuse Prevention Policy- Long Term Care #9859864 was reviewed by St. Benedict□s Community Leaders and direct resident care employees on June 17 □ 20, 2022. In review of the grievance filed on 1/16/2022, discussion with employees to demonstrate clarity and understanding of policy. Moving forward, new employee orientation will include training on the policy by Education Staff. Unit Nursing Supervisors and Unit Social workers will round at a minimum of once a day with staff and residents to identify any concerns in patient care with documentation of visiting with residents in the patient□s health record. On July 11, 2022, it was determined to promote consistency of practice in understanding and following the Vulnerable Adult Abuse and Reporting Policy, an algorithm of the process will be developed for training and education for all direct care employees, Unit Nursing Supervisors, and new employees during onboarding by Regional Education Department and Director of Nursing. Mandatory training will be conducted using scenario-based learning to all direct care employees and Unit Nursing Leaders to validate understanding	

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F 610	Continued From page 6 investigation. . .Immediately remove any alleged perpetrator(s) from their duties and place on administrative leave until the completion of the facility investigation."	F 610	and competency of algorithm of the Vulnerable Adults Abuse Prevention Policy Long Term Care to be completed by August 1, 2022, under the direction of Regional Educator Senior Services and Director of Nursing to achieve compliance by August 1, 2022.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to comprehensively assess and monitor a wound for 1 of 1 residents (R70) reviewed for wound care. Findings include: R70's face sheet printed 6/16/22, indicted R70's diagnoses included; diabetes, neuropathy (damage or dysfunction of one or more nerves that typically results in numbness, tingling, muscle weakness and pain in the affected area), peripheral vascular disease (a slow and progressive circulation disorder), and cerebral infarction (occurs because of disrupted blood flow to the brain due to problems with the blood vessels that supply it).	F 684	Upon findings of R70 deficiency related to wound assessment and documentation, Licensed Nursing staff completed wound assessment and proper documentation following Policy #11188948 of R70 wounds. June 20, 2022, Review of Wound Assessment and Documentation Long Term Care Policy #11188948 reviewed by St. Benedict□s Community Leaders and Unit Nursing Supervisor to discuss the procedure outlined to provide guidance for through and consistent wound assessment and documentation. Unit Nursing Supervisors will be monitoring and verifying completion and documentation of weekly skin assessments of residents which is	8/1/22

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F 684	Continued From page 7 R70's annual Minimum Data Set dated 2/16/22, indicated R70's was cognitively intact. R70's skin and wound evaluation dated 5/18/22, indicated R70 had two abrasions scabbed over on her left shin that measured: length 1.8 centimeters (cm) x 0.5 cm width and 0.9 cm x 0.4 cm. R70's medical record lacked evidence of other wound assessments or wound care orders after the wounds were first identified. R70's care plan dated 5/19/22, directed staff to inspect R70's skin as needed with cares and licensed nurse to observe R70's skin weekly. During an observation on 6/13/22, at 3:02 p.m. R70 was sitting in her recliner wearing short pants and her left leg elevated on the footrest. She had two shin abrasions. R70 stated the abrasions had been there a long time. During an observation on 6/14/22, at 2:57 p.m. R70 was sitting in her recliner wearing short pants and her left leg elevated on the footrest. The abrasions were easily observed on the left shin. During an interview on 6/14/22, at 12:59 p.m. nursing assistant (NA)-J stated she did not notice any skin issues with R70 during morning cares. During an interview on 6/14/22, at 2:19 p.m. registered nurse (RN)-B stated he would expect staff to inform the nurse of any skin issues and he would look at the area.	F 684	performed by Licensed Nursing staff on resident□s scheduled bath day. If resident refuses bath, instruction will be given to licensed nursing staff stating the skin assessment still needs to be completed and documented before the end of their shift. Unit Nursing Supervisors or their designee will audit weekly until full compliance is sustained for one month on their Unit. Completion of resident skin assessments will include photos if applicable. Unit Nursing Supervisors will conduct weekly audits of Skin assessments UDAs on their Unit to ensure compliance as scheduled for one month. Review of audits will be completed quarterly at the Quality Assurance Performance Improvement Meetings as a standard agenda item beginning July 20, 2022. Ensuring timely completion of assigned UDAs on each Nursing Unit will be done at Leadership Morning Huddles on Monday, Wednesday, and Friday each week until sustainability demonstrated for one month of timely completion of all UDAs on all Nursing Units. Auditing and Monitoring 10% of patient records will begin on July 13, 2022. Process change toward compliance of corrective action will be led by Unit Nursing Supervisors and monitored by Director of Nursing and Assistant Director of Nursing.	

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F 684	Continued From page 8 During an observation on 6/15/22, RN-B stated R70's left shin had scabbed abrasions on it. RN-B stated staff should complete and document a skin assessment on bath days. RN-B stated there was no documentation that a skin assessment was completed for R70 since 5/18/22. Therefore it was not completed. During an interview on 6/16/22, at 9:33 a.m. the clinical manager (CM)-D stated on bath days R70 should have a weekly skin check completed. CM-D stated R70 had not refused any baths since 5/18/22. CM-D stated R70 should have weekly skin assessments completed, even if R70 declined a bath. CM-D confirmed the skin assessments were not completed. The facility's Wound Assessment and Documentation policy dated 2/2022, indicated staff will consistently measure, assess, classify, identify, and grade/stage wound, and document findings in the electronic medical record (EMR).	F 684		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced	F 687		7/18/22

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F 687	Continued From page 9 by: Based on observation, interviews, and record review, the facility failed to ensure 1 of 1 resident (R69) was provided diabetic foot care. Findings include: Review of R69's quarterly Minimum Data Set (MDS) dated 05/27/22, indicated R69 was cognitively intact, had type 2 diabetes mellitus, and required extensive assistance of one staff member for bed mobility and transfers. Review of a document, "Podiatry Group," dated 04/03/22, indicated R69 was diabetic, and the podiatrist trimmed his toenails. During an interview on 06/13/22 at 1:26 p.m. a family member (FM)-1 assisted R69 to remove his socks. The fourth and fifth toes on both the right and left side required trimming. The toenails extended about 1/4 inch beyond the tips of these toes. During an interview on 06/15/22, at 9:12 a.m. the Clinical Manager (CM)-A stated nursing completed the "Skin Impairment Evaluation" which included an assessment of a resident's toenails. On 06/15/22, at 9:22 a.m. CM-A entered R69's room and asked for permission to observe the condition of his toenails. CM-A confirmed the resident's fourth and fifth toes on both feet needed to be trimmed. Review of a policy provided by the facility titled "Foot Care-Long Term Care," dated 02/22, indicated ". . .To provide foot care for residents and/or assist with making appointments for residents with a qualified person, and arranging	F 687	During survey it was found that R69, being a type 2 diabetic, had on both feet the fourth and fifth toes required trimming. The toenails extended about ¿ inch beyond the tips of these toes. On site Podiatry Provider visits were refused by Provider due to COVID. Podiatry Provider was notified of residents need for services at their earliest possible time. A list for Podiatry on Monday 7/11 and Tuesday 7/12, was emailed to all resident care units with the following directions: " We will have everything ready to go for each of these visits. " They will be seeing NW, GG and TW residents on Monday. " They will be seeing SP residents on Tuesday. " Please □ if you notice that there are residents that are wanting or needing Podiatry that are NOT on the list □ let me know and we will get them added. Podiatry services visits to St. Ben□s were held with all residents on the lists provided with services as stated above. June 20, 2022, Policy Foot Care □ Long Term Care #11140966 was reviewed by St. Benedict□s Community Unit Nursing Supervisors and discussed assessment of feet to be included in skin assessment with each scheduled bathing. If resident refuses bathing, feet should still be assessed, and documentation of findings completed by Registered Nurse. If concerns noted upon assessment, policy should be followed, and arrangements made for further assessment and treatment of foot care as soon as	

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F 687	Continued From page 10 for transportation to and from such appointments. . .Nursing personnel should check medical record for diagnosis of Diabetes. . . If resident's toenails are such that can't be cut by nursing staff, referral to podiatry will be offered to resident and/or representative. . ."	F 687	possible. Unit Nursing Supervisor will audit 10% of resident records weekly along with completion of skin assessment UDAs that foot care is being assessed and documented for compliance. Auditing will begin July 13, 2022, and continued until compliance with policy is sustained for one month with skin assessments. Process change toward compliance of corrective action will be led by Unit Nursing Supervisors and monitored by Director of Nursing and Assistant Director of Nursing.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a can of bug spray was appropriately secured where residents could not access it. This had the potential to affect 29 residents on the unit. Finding include: During an observation on 6/14/22, at 12:38 p.m. a 16 ounce (oz) can of wasp/yellow jacket spray was on the mantel above the fireplace in the room, across from the desk on the fourth floor.	F 689	During the MDH Survey on June 13-16, 2022, a Wasp Spray can was noted to be stored on the mantel on a patient care unit within reach of clients. Director of Nursing was asked to accompany surveyor to resident unit Summit Place. As surveyor and Director of Nursing walked towards an open patient lounge area where the survey instructed the Director of Nursing to look around the area and what do you see? Within minutes, Director of Nursing identified the Wasp Spray Can setting in	7/18/22

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F 689	Continued From page 11 When the spray can was lifted it felt full. During an observation on 6/15/22, at 8:02 a.m. the 16 oz. can of wasp/yellow jacket spray remained on the mantel. During an observation on 6/15/22, at 1:09 p.m. the 16 oz. can of wasp/yellow jacket spray remained on the mantel. During an interview on 6/16/22, at 9:30 a.m. the director of nursing (DON) stated the 16 oz can of wasp/yellow jacket spray should not be on the fireplace mantel. The DON stated it should be stored in the maintenance area or locked up in the environmental closet. The DON stated it should not be where the residents could access it. During an interview on 6/16/22, at 10:54 a.m. the administrator stated the wasp spray should be stored on the ground floor storage room and not on the mantel. The Materials Safety Data Sheet (MSDS), undated, indicated the wasp/yellow jacket spray was harmful if swallowed or if absorbed through the skin. The policy further revealed contents were under pressure and should be stored away from heat, sparks, open flame, or other ignition source. Keep away from food, drink, and animal feeding stuffs. Keep out of the reach of children. A facility policy Hazard Communication and Employee Right to Know Program dated 9/21, lacked information on storage of chemicals.	F 689	corner ledge of mantel. Immediately Director of Nursing took Wasp Spray Can off mantel and informed surveyor that the Wasp Spray Can is to be removed immediately after usage and stored in Hazardous Materials Cabinet in maintenance department. After visiting with surveyor on the resident care unit, Director of Nursing with Wasp Spray Can in her hand, took item to maintenance department and informed maintenance staff that Wasp Spray Can was found sitting on mantel in the patient lounge area on Summit Place. Director of Nursing questioned maintenance employee on the proper storage of the spray which was answered by maintenance that the storage of such items is to be stored in a hazardous storage cabinet located in the maintenance storage area. Reviewed proper storage of Hazardous Materials and when such items are taken to the resident units by maintenance, the product(s) are to be returned to maintenance hazards storage area after each use on a resident patient unit. On June 18, 2022, Hazard Communication and Employee Right to Know Program Policy reviewed with Administrator, Maintenance Supervisor, and Director of Nursing. The purpose of this program is to provide all staff the knowledge of hazards from chemical, physical, and infectious materials with their department through use of evaluation, inventory, labeling, record keeping, and training of the hazards. The Materials Safety Data Sheet was reviewed by Administrator,	

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F 689	Continued From page 12	F 689	Maintenance Supervisor, and Director of Nursing. The contents under pressure should be stored away from heat, sparks, open flame, or other ignition source. Keep away from food, drink, and animal feeding area. Keep out of the reach of children. Such products are stored on ground floor storage room in the maintenance area and is obtained by contacting a maintenance employee if such items are warranted. Maintenance employee will review issue present that was reported to identify corrective maintenance needed. The facility will protect residents in similar situations moving froward from day of finding to ensure protection of residents and staff to exposure of hazardous materials. When supplies are brought into a residential area from maintenance, the resident(s) and staff are moved into a safe location outside of the parameter of risk from the product(s). Upon completion of task, Maintenance employee will return all supplies to maintenance storage area. Unit Nursing Supervisor or designee will check area of concern for residue items, smells, or supplies and if remaining items are found will contact maintenance immediately to come and remove items and return to proper storage area immediately. Maintenance team or designee(s), under the direction of Supervisor will audit residential areas for safety and absence of hazards weekly x one month starting July 15, 2022, if no concerns found, will decrease to every two weeks starting August 1, 2022. Review of audits will be shared with facility	

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F 689	Continued From page 13	F 689	leadership morning huddles held on Monday, Wednesday, and Friday at 0915am. Maintenance Supervisor and Administrator will oversee this auditing process.	
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure admitted residents were seen by a physician once every 30 days for the first 90 days for 1 of 1 resident (R70) reviewed for frequency of physician visits. Findings include:	F 712	On June 18, 2022, Provider Services □ Long Term Care was reviewed by Facility Administrator and Director of Nursing with resident(s) care team including service providers from Dialysis, Medical Directors, Unit Nursing Supervisors, Unit Social Workers, and Health Information Services Supervisor regarding Physician visits	7/18/22

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F 712	Continued From page 14 R70's face sheet printed 6/16/22, indicated R70 was admitted to the facility on 2/28/21. R70's diagnoses included diabetes, neuropathy (damage or dysfunction of one or more nerves that typically results in numbness, tingling, muscle weakness and pain in the affected area), peripheral vascular disease (a slow and progressive circulation disorder), and cerebral infarction (occurs because of disrupted blood flow to the brain due to problems with the blood vessels that supply it). On 6/16/22, at 11:30 a.m. a review of R70's medical record lacked evidence of a provider visit/tele visit since 3/10/22. During an interview on 6/16/22, at 12:30 a.m. the director of nursing (DON) stated there were no provider notes from any visit since 3/10/22. The DON stated R70 had not been seen via tele visit or in person by the provider. During an interview on 6/16/22, at 1:02 p.m. the DON stated R70 should be seen by her provider every 60 days. During an interview on 6/16/22, at 2:19 p.m. health unit coordinator (HUC)-H stated there was no appointment made for R70 to see her provider in the office. The facility policy Provider Services dated 10/22, indicated the facility would schedule or coordinate provider visits at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.	F 712	requirements within the Skilled Nursing Facility. R70□s chart was further reviewed to determine which physician visits were missed and rational. Director of Nursing and Administrator along with Health Information Systems discussed with Dialysis providers regulations regarding provider services in Long Term Care setting, On July 13, 2022, monitoring of provider services in Long Term Care will be completed by Unit Nursing Supervisor 30 days after admission of resident(s), every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. Findings will be addressed immediately upon finding visit not scheduled prior to above guidelines. Process monitoring for compliance will be completed by Health Information Services Supervisor. Health Information Systems reviewed current physician visit rotation of dialysis resident to identify how visits were missed and identified process of contacting physician and scheduling visits by physician as stated above.	
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		8/1/22

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F 883	Continued From page 15 §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is	F 883		

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F 883	Continued From page 16 medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise their pneumococcal vaccine policy to current pneumococcal vaccination guidelines. This failure increased the risk for residents not vaccinated to contract pneumonia. Findings include: Review of a policy titled "Pneumococcal Immunization, Long Term Care," dated 06/22, indicated ". . .Residents will be offered the pneumococcal vaccinations and administered, according to the MDH and CDC recommended interval for the vaccines, unless contraindicated, already immunized, or the resident and/or the resident representative declines the vaccine. . .Definitions. . .Prevnar - PCV13 - Pneumococcal Conjugate 13 Valent. . .Pneumovax - PPV23 - Pneumococcal Polysaccharide 23. . .Each resident's eligibility or contraindications to receive the pneumococcal vaccine will be determined by	F 883	Pneumococcal Vaccination, Long Term Care Policy due for review 06/22. Director of Nursing from St. Benedict□s will address need of changes to Policy with review by LTC Director of Nursing group on July 14, 2022, with changes to be made to include CDC recommendations of the following: " CDC recommends pneumococcal vaccination for all adults 65 years or older " For adults 65 years or older who have not previously received any pneumococcal vaccine, CDC recommends: o Give 1 dose of PCV (Pneumococcal Conjugate Vaccine) 15 or PCV20 ¿ If PCV15 is given, this should be followed by a dose of PPSV (Pneumococcal Polysaccharide Vaccine) 23 at least one year later ¿ The minimum interval is 8 weeks and can be considered in adults with an	

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F 883	Continued From page 17 utilizing the attached algorithm. . ." However, the policy lacked the updated CDC guidance: "Pneumococcal Vaccination: Summary of Who and When to Vaccinate," effective 01/28/22, indicated ". . . CDC recommends pneumococcal vaccination for all adults 65 years or older . . . For adults 65 years or older who have not previously received any pneumococcal vaccine, CDC recommends you . . . Give 1 dose of PCV [Pneumococcal Conjugate Vaccine] 15 or PCV20 . . . If PCV15 is used, this should be followed by a dose of PPSV [Pneumococcal Polysaccharide Vaccine] 23 at least one year later. The minimum interval is 8 weeks and can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak . . . If PCV20 is used, a dose of PPSV23 is NOT indicated . . . For adults 65 years or older who have only received a PPSV23, CDC recommends you . . . May give 1 dose of PCV15 or PCV20 . . . The PCV15 or PCV20 dose should be administered at least one year after the most recent PPSV23 vaccination. Regardless of if PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it. For adults 65 years or older who have only received PCV13, CDC recommends you . . . Give PPSV23 as previously recommended . . . For adults who have received PCV13 but have not completed their F883 recommended pneumococcal vaccine series with PPSV23, one dose of PCV20 may be used if PPSV23 is not available. If PCV20 is used, their pneumococcal vaccinations are complete . . . " During an interview on 06/16/22 at 11:05 AM, the Director of Nursing (DON) stated she was aware	F 883	immunocompromising condition, cochlear implant, or cerebrospinal fluid leak. ¿ IF PCV20 is used, a dose of PPSV23 is not indicated " For adults 65 years or older who have only received a PPSV23, CDDC recommends: o Give 1 dose of PCV15 or PCV20. o The PCV15 or PCV20 dose should be administered at least one year after the most recent PPSV23 vaccination. o Regardless of if PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it. " For adults 65 years or older who have only received PCV13, CDC recommends: o Give PPSV23 as previously recommended " For adults who have received PCV13 but have not completed the recommendation of change on 1/28/2022 recommendation of pneumococcal vaccine series with PPSV23: o One dose of PCV20 may be used if PPSV23 is not available. o If PCV20 is used, their pneumococcal vaccinations are complete. Policy will be updated during the LTC Director of Nursing group meeting on July 14, 2022 and submitted with changes to be published in CentraCare PolicyStat program where all CentraCare Policies are stored for use by August 1, 2022.	

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	245350	A. BUILDING _____ B. WING _____	C 06/16/2022

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F 883	Continued From page 18 of the new CDC guidelines for pneumococcal vaccines and the facility should have identified the new guidance and updated the policies when they were reviewed this year.	F 883		

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ST BENEDICTS SENIOR COMMUNITY	**1810 MINNESOTA BOULEVARD SOUTHEAST** **SAINT CLOUD, MN 56304**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted on 06/14/2022, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Benedicts Senior Community was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/15/2022

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

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K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. St. Benedicts Senior Community is a 5-story building with a full basement and an Elevator Equipment Penthouse. The building was constructed at 2 different times. The original building was constructed in 1978 and was determined to be of Type 1(332) construction. In 1997, a 2 story addition was added to the northeast that was determined to be of Type II(111) construction. Also in 2008, there was a 2 story, with no basement determined to be a Type II (111). Because the original building and the	K 000		

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K 000	Continued From page 2 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered and has a fire alarm system with smoke detection in the corridors and areas open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 174 beds and had a census of 98 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET.	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K 321		7/26/22

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K 321	Continued From page 3 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for a hazardous storgae room per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, and 19.3.2.1.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/14/2022 at 10:55 AM, it was revealed by observation that the 3rd floor conference room across from the nurse's station was re-purposed into a storage/supply room. It was also observed that the door to this room was not self-closing. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 321	Any time a building room is repurposed, facility will not move forward with plan until proper fire rated door is installed. The Administrator, Regional Director of Maintenance, and CentraCare facilities staff will review any room re-purposing moving forward to ensure this practice does not recur. The next 3 room repurposing's, facility will have an audit done prior to moving forward to ensure the appropriate positions signed off on the project to move forward. This will monitor compliance. The door meeting specifications listed above has been ordered by Maintenance Supervisor with estimated arrival of October 2022. Door and closure to be stalled upon delivery in October 2022.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking	K 324		7/18/22

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K 324	Continued From page 4 Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect cooking areas per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 06/14/2022 at 10:35 AM, it was revealed by observation that a portable flat style electrical griddle is being used in the 4th floor kitchenette to make fried eggs, pancakes, and grilled cheese sandwiches with the use of butter and spray vegetable oil release agents causing the release	K 324	Electrical griddles being used on all floors kitchenettes were removed on 7/11/2022. Dietary department has agreed to allow residents with special meal requests to place order on meal ticket the meal prior. Breakfast special requests need to order by 7pm the night prior. Lunch special requests need to order by 10am and dinner special requests need to order by 3pm. Resident satisfaction with meals will be monitored daily by Unit staff assisting with meal tray delivery for two weeks to determine process success or need for revision. Unit Social Workers will oversee the	

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K 324	Continued From page 5 of grease laden vapors. The portable flat style electrical griddle was not being used in conjunction with a ventilation hood with fire suppression. 2. On 06/14/2022 at 11:00 AM, it was revealed by observation that a portable flat style electrical griddle is being used in the 3rd floor kitchenette to make fried eggs, pancakes, and grilled cheese sandwiches with the use of butter and/or spray vegetable oil release agents causing the release of grease laden vapors. The portable flat style electrical griddle was not being used in conjunction with a ventilation hood with fire suppression. 3. On 06/14/2022 at 12:10 PM, it was revealed by observation that a portable flat style electrical griddle is being used in the 2nd floor kitchenette to make fried eggs, pancakes, and grilled cheese sandwiches with the use of butter and/or spray vegetable oil release agents causing the release of grease laden vapors. The portable flat style electrical griddle was not being used in conjunction with a ventilation hood with fire suppression. 4. On 06/14/2022 at 12:20 PM, it was revealed by observation that a portable flat style electrical griddle is being used in the ground floor kitchenette to make fried eggs, pancakes, and grilled cheese sandwiches with the use of butter and/or spray vegetable oil release agents causing the release of grease laden vapors. The portable flat style electrical griddle was not being used in conjunction with a ventilation hood with fire suppression. An interview with Maintenance Supervisor verified	K 324	monitoring to measure resident satisfaction with process started on July 18, 2022.	

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K 324	Continued From page 6 these deficient findings at the time of discovery.	K 324		
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.2, 19.7.1.6, and 4.7.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 06/14/2022, at 9:05 AM, during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility failed to conduct an overnight shift fire drill in the second calendar quarter of the year. 2. On 06/14/2022, at 9:05 AM, during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not vary the times of	K 712	On June 20, 2022, Maintenance department meeting was held with training to ensure that fire drills will be conducted as required, at expected intervals and at random times within the appropriate intervals. The 3rd shift drills will be completed by facilities team moving forward to provide improved oversight and accountability of drills.	7/15/22

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K 712	Continued From page 7 the fire drills by conducting 3 of the 4 evening shift fire drills in the 3 PM hour. An interview with the Maintenance Supervisor verified these deficient findings at the time of the discovery.	K 712		
K 901 SS=C	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility has failed to provide a complete facility Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/14/2022, at 10:15 AM, during a review of available documentation and an interview with the Maintenance Supervisor, it was revealed that the facility provided a utility risk assessment document that did not contain a complete list of the electrical and gaseous patients/residents care	K 901	The Risk Assessment was assigned and completed by clinical engineering on July 12, 2022, using the 4 levels of Risk scale with findings shared with maintenance team, Administrator, and Director of Nursing.	7/18/22

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K 901	Continued From page 8 equipment and the associated risk categories for the patients/residents as outlined in 2012 edition of NFPA 99, The Health Care Facilities Code chapters 10 and 11. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 901		