

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER St Benedicts Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1810 Minnesota Boulevard Southeast Saint Cloud, MN 56304	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0777</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083</p> <p>Based on interview and document review, the facility failed to notify the ordering physician of x-ray results, which revealed newly identified fractures, in a timely manner for 1 of 3 residents (R1) reviewed.</p> <p>Findings included:</p> <p>R1's annual Minimal Data Set (MDS) dated [DATE], indicated R1's had a diagnosis of severe vascular dementia with anxiety and mood disturbance.</p> <p>R1's Progress Notes revealed the following:</p> <p>-On 7/15/24 @ 12:17 p.m., R1 reported he fell overnight last night in his bathroom, however, was unable to describe the fall, if he was using an assistive device, and how he got up off the floor. R1 reported pain in his ribs on the left side but no skin alterations were noted at the time. Physician updated and staff requested an x-ray for the left side ribs.</p> <p>-On 7/15/24 at 6:01 p.m., R1 reported pain 7 out of 10 and pain got worse with movement. X-ray was obtained and staff were awaiting results. Physician ordered 25 milligrams (MG) Tramadol twice daily and as needed for pain.</p> <p>-On 7/15/24 at 9:43 p.m., X-ray results obtained by fax and were as follows: 1. Subacute mildly displaced fracture to left 9th and 10th ribs. In comparison with prior examination, fractures were not visible on prior study and may be new since prior study. Staff would update R1's daughter via phone and put the x-ray report in the physician's folder.</p> <p>Progress notes lacked evidence of staff notifying physician of x-ray results.</p> <p>On 7/25/24 at 10:55 a.m., licensed practical nurse (LPN)-A stated she was R1's floor nurse on the day R1's x-rays were obtained, and the results were received between 7:30 and 9:00 p.m. LPN-A stated the x-ray results revealed R1 had fractures of his 9th and 10th ribs. LPN-A stated she then notified R1's family by phone, and notified the physician by fax and called the on-call nurse. Further, LPN-A could not recall which nurse she notified. LPN-A stated staff were expected to notify the resident's physician, supervisor, and family right away when staff were aware of a significant injury.</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0777</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/25/24 at 12:20 p.m., registered nurse (RN)-A stated she became aware of R1's x-ray results on the morning of 7/16/24, at approximately 9:00 a.m. when she went searching for the faxed results. RN-A discovered the x-ray results were received the night prior at approximately 9:30 p.m., and R1's floor nurse would have been LPN-A. RN-A stated LPN-A failed to notify R1's physician or the on-call nurse, which would have been the director of nursing (DON). RN-A stated R1's physician and DON were not aware of R1's fractures until RN-A notified them both on the morning of 7/16/24. RN-A stated staff were expected to notify the physician and the on-call nurse immediately when staff become aware of a serious injury. RN-A stated as part of the investigation, staff were educated on importance of following a resident's plan of care specifically regarding toileting and repositioning, but RN-A was not aware of education related to reporting serious injuries timely.</p> <p>On 7/25/24 at 1:18 p.m., DON stated she received a call from RN-A on 7/15/24, in the morning, and RN-A had reported R1 self-reported a fall and had been complaining of increased pain and the physician was notified and ordered x-rays. Further, DON confirmed LPN-A did not notify the physician or the on-call nurse, which would have been the DON, upon receiving R1's x-ray results. DON discovered LPN-A had put the x-ray results on the board for the physician which was for non-emergent things and LPN-A should have immediately called the physician with the x-ray results. In addition, DON stated she was not aware of the delay in notifying the physician or on-call nurse until 7/25/24, and was attempting to interview LPN-A regarding the reasoning as to why LPN-A didn't feel she needed to update the physician when she knew R1 had newly diagnosed fractures. DON stated staff were expected to report serious injury or injuries of unknown as soon as they were aware of an injury.</p> <p>Review of facility policy titled Acute Condition Changes revised 3/18, indicated direct care staff would be trained on recognizing subtle but significant changes in the resident and how to communicate those changes to the nurse. Phone call to the attending or on-call physicians should be made by an adequately prepared nurse who had collected and organized pertinent information, including the resident's current symptoms and status. The nursing staff would contact the physician based on the urgency of the situation. For emergencies, they would call or page the physician and request a prompt response (within approximately one-half hour or less).</p>		