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	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Benedicts Care Center	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to follow manufacturer's recommendation and facility policy to ensure safe transfers with an EZ Way Smart Lift (mechanical, full body lift) for 1 of 3 resident (R1) reviewed for full body mechanical lift transfers. R1 fell out of the sling and sustained a laceration to his right eyebrow, was sent to the Emergency Department (ED), and required sutures. The facility implemented corrective action prior to the survey; therefore, the deficient practice was issued at past non-compliance.Findings included:R1's admission record dated 12/4/25, indicated R1's diagnoses included palliative care, wild-type transthyretin-related amyloidosis (build-up of abnormal proteins in tissues, such as heart and nerves), chronic kidney disease stage four (severe, irreversible loss of kidney function), and rhabdomyolysis (breakdown of skeletal muscle tissue).R1's care plan dated 12/4/2025, indicated R1 needed a full mechanical lift with assist of two staff for transfers.R1's significant change Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact, had no falls, and needed total assistance with transfers.R1's progress note dated 3/29/26 at 11:07 a.m., indicated at 9:14 a.m., staff was informed R1 was on the floor, licensed practical nurse (LPN)-A entered R1's room and R1 was on his right side and had a laceration approximately two inches above right eye.R1's progress note dated 3/29/26 at 12:36 p.m., indicated the ED nurse called the facility and stated R1's eyebrow laceration was deeper than they thought and needed multiple layers of dissolvable sutures due to laceration being the depth of the bone.R1's ED note dated 3/29/26, indicated R1 had a 5.0cm (centimeter) laceration to his right eyebrow after a fall from a mechanical lift. Was given oxycodone 10mg (milligram) and lidocaine-epinephrine (used to numb specific area) injection. R1 required 19 sutures placed in right eyebrow.During an interview on 4/8/26 at 12:12 p.m., nursing assistant (NA)-A stated on 3/29/26, she entered R1's room to assist NA-B with a full body lift transfer. NA-B had already hooked R1's sling to the lift. NA-A stated she did not double check to ensure R1's sling was attached to the lift correctly. NA-A stated that according to the policy she should have double checked the sling straps to ensure they were attached correctly but it, slipped her mind. NA-A stated NA-B lifted R1 with the full body mechanical lift until he was no longer touching his wheelchair. NA-A pulled the wheelchair out from under R1 and R1 fell out of the lift when the right shoulder strap came off the lift. R1 fell on his right side and was bleeding from his right eyebrow.During an interview on 4/8/26 at 1:46 p.m., LPN-A stated on 3/29/26 around 9:00- 9:30 a.m., NA-B alerted LPN-A R1 had fallen and was on the floor. LPN-A went to R1's room and found him on the floor on his right-side bleeding from his right eye. LPN-A sent R1 into the ED.During an interview on 4/8/26 at 1:56 p.m., EZ Way representative stated she was aware of R1's fall from the lift. The expectation would be for staff to follow the instruction manual which included a final check to ensure all four loops were attached sufficiently to the respective hook of the hanger bar on the lift. If staff would have followed the manual and facility policy, R1's fall might have been prevented. During an interview on 4/8/26 at 2:21 p.m., the facility medical director stated if the staff had checked the straps per the policy they would have caught the issue and R1 would not have fallen and gotten injured.During an interview on 4/8/26 at 2:36 p.m., the director of nursing (DON) stated staff did not (continued on next page)

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	follow the process put into place and R1 fell from the lift due to the sling not being hooked to the lift correctly. The straps were not checked to ensure they were on the lift correctly by the second staff member.Facility policy, Using a Mechanical Lifting Machine revised 7/2017, indicated staff would attach sling straps according to manufacturer's instructions, would make sure the sling was securely attached to the hooks, before lifting the resident staff would double check the security of the sling attachment, examine all hooks, and would check the stability of the straps.EZ-Way Smart Life Operator's Instructions revised 2/10/2026, directed staff to make a final check of all four loop attachment points to ensure each loop was sufficiently attached to the correct hook of the hanger bar.The facility's corrective actions following this incident were confirmed through observation, interview, and record review of staff completing full body mechanical lift transfers with residents per policy and manufactures instructions, staffs ability to explain expectations of full body mechanical lift transfers, and review of re-education and audits completed with staff.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and document review, the facility failed to ensure staff consistently implemented enhanced barrier precautions (EBP) in accordance with Centers for Disease Control (CDC) guidelines to reduce the risk of infection spread for 1 of 3 residents (R1) reviewed for transfers.Findings include:R1's admission record dated 12/4/25, indicated R1's diagnoses included benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms.R1's care plan dated 3/4/26, indicated R1 had an indwelling foley catheter.R1's order summary report dated 3/4/26, indicated R1 had a foley catheter.During an observation on 4/7/26 at 12:45 p.m., nursing assistant (NA)-C and NA-D entered R1's room to transfer R1 from his wheelchair to another wheelchair for an appointment. R1 did not have signage or supplies for EBPs on his door or in his room. NA-C and NA-D did not have any EBPs (gown and gloves) on during R1's transfer. R1's lift sling was hooked to the full body mechanical lift. NA-C grabbed R1's catheter bag from under his wheelchair and attached it to the sling. R1 was placed in the new wheelchair and NA-D grabbed R1's catheter bag and attached it under the wheelchair.During an interview on 4/7/26 at 1:44 p.m., NA-C stated residents who have wounds or catheters should be on EBPs. R1 did have a foley catheter but NA-C was not sure why R1 was not on EBPs. The unit manager would decide who was on EBPs. NA-C did not wear EBPs when transferring R1 because R1 did not have the signage or supplies on his door and that is how NA-C would have known if someone was on EBPs. During an interview on 4/7/26 at 1:53 p.m., NA-D stated residents with open sores or catheters would have been on EBPs. R1 has a foley catheter. NA-D was not sure why R1 was not on EBPs as the nurse would decide who is placed on EBPs. NA-D did not use EBPs when transferring R1 because there was nothing on the door indicating NA-D needed to use EBPs.During an observation on 4/8/26 at 8:19 a.m., an EBP sign and personal protective equipment (PPE) was observed hanging on the outside of R1 room door.During an interview on 4/8/26 at 9:25 a.m., registered nurse (RN)-A stated R1 had a foley catheter and after clarification, R1 should have been on EBPs and was not until 4/7/26. RN-A stated she was the one responsible for putting signage on the resident's door and equipment outside the resident's room related to use of EBPs.During an interview on 4/8/26 at 2:36 p.m., the director of nursing (DON) stated RN-A would have been responsible for putting R1 on EBPs and was able to determine if a resident needed EBPs by following the facility policy. DON was not sure why R1 was not placed on EBPs prior to 4/7/26.The facility policy titled, Enhanced Barrier Precautions revised 12/2024, indicated EBPs would be applied when a resident had a wound or indwelling medical device. Indwelling medical devices include urinary catheters. Gowns and gloves would be applied when performing high contact resident activities including transfers.