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	05/15/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 1 residents (R27) reviewed for dignity, received services in a dignified manner to promote quality of life when staff failed to respond timely to call light and provide toileting assistance resulting in incontinent episodes and adult son of R27 provided toileting assistance. Findings include: R27's admission minimum data set (MDS) dated [DATE], indicated R27 was cognitively intact, did not reject cares and was dependent on staff assistance for all toileting needs. During an interview on 5/12/25 at 1:49 p.m., R27 stated she needed help to use the bathroom, some call light times exceeded 20 minutes and once over two hours. R27 stated there had been times she became incontinent because of the long wait time. It was embarrassing. R27 stated during a visit with family on Mother's Day (5/11/25) she had turned on her call light and requested help to use the bathroom. Staff came to the room, shut the light off and said they would be right back. When staff had not returned after approximately 5 minutes, R27 turned the light back on. Again, staff came in and shut the light off and said they would be right back. When staff did not return immediately, she was assisted to the bathroom by her adult son. R27 stated it was horrible, he had to pick me up and carry me. My son, not my husband. R27 shook her head and looked away and stated, how would that make you feel? I hated it. R27 stated she was embarrassed and ashamed her son had to help her with such a personal thing. R27 stated her son turned the call light on after transferring her into the bathroom so staff could assist with helping her off the toilet. R27 stated staff came after a couple of minutes and stated they would come back to assist when she was finished. R27 stated she was done about 15 minutes later and pushed for assistance and staff then came to help. Review of call light call logs indicated the following data: 5/11/25 R27's call light was activated at 1:03 p.m. and staff responded within 11 seconds. 5/11/25 R27's call light was activated at 1:06 p.m. and staff responded within 8 seconds. 5/11/25 R27's call light was activated at 1:37 p.m. Staff responded within 1 minute and 24 seconds. 5/11/25 R27's call light was activated at 1:47 p.m. and staff responded within 2 minutes and 16 seconds. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/11/25 R27's call light was activated at 5:38 p.m. and staff responded after 29 minutes and 16 seconds. During interview on 5/14/25 at 11:32 a.m. Director of Nursing (DON) stated all staff can answer call lights, but primarily they are answered by certified nursing assistants (CNA). DON stated typically call lights were answered right away but it was reasonable to expect a 5-10-minute wait time during busier times of days such as early morning, mealtimes and bedtimes. DON stated she expected staff to check in with residents who use their call light and if multiple lights are on at once, to triage the highest priority lights first, and always return to residents and follow up that their needs are met. DON stated it could be embarrassing for a continent resident to become incontinent as a result of extended wait times and it is important that all residents' needs are met timely to promote dignity and general wellbeing. A policy for dignity was requested but not provided.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure the care plan included management and monitoring of anticoagulant (blood thinner) therapy for 1 of 5 residents (R1) reviewed for unnecessary medications. Findings include: R1's admission minimum data set (MDS) dated [DATE], indicated R1 was cognitively intact, received anticoagulation medications and had the following diagnoses: A-fibrillation (irregular heartbeat), Acute Embolism and Thrombosis of Deep Veins (blood clots within a blood vessel), and heart failure. R1's order summary report printed 5/14/25 indicated R1 took the following medications: Warfarin 1 mg by mouth one time daily every Friday for A-fib. Warfarin 1.5 mg by mouth one time a day every Monday, Wednesday for A-fib. Warfarin 2 mg one time every Tuesday, Thursday, Saturday and Sunday for A-fib. R1's care plan printed 5/13/25 identified a potential for injury related to history of falls, decreased/impaired mobility, diuretic medications and decline in activities of daily living. R1's care plan lacked evidence of anticoagulant use, increased risk for bleeding, or need for anticoagulant side effect monitoring. During interview on 5/13//25 at 10:13 a.m. registered nurse manager (NM) stated residents on anticoagulant therapy should be monitored for increased bruising, bleeding and staff should be aware of risks associated with these medications. During interview with Director of Nursing on 5/14/25, at 11:32 a.m. Director of Nursing (DON) confirmed R1 was receiving anticoagulant therapy. DON stated residents receiving anticoagulant therapy care plans should include anticoagulant use and instruct staff to monitor for potential side effects including bleeding risks, and an increased risk for bruising. DON confirmed R1's care plan lacked evidence of a focus area related to anticoagulant therapy or monitoring for side effects of anticoagulant therapy. DON stated she expected care plans to include staff instructions for monitoring of side effects related to anticoagulant therapy, completing associated labs as ordered by physicians and updating physicians with any pertinent findings. DON stated this was important because a resident was at a higher risk for complications related to these medications and potential accidents could result in increased bleeding or a resident bleeding out. Facility policy Anticoagulation-Clinical Protocol dated 2018, instructed staff to, Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications. The policy instructed staff to monitor for possible complications such as excessive bruising, hematuria (blood in urine), hemoptysis (coughing up blood), or other bleeding and to contact provider before administering next dose of anticoagulant. A care plan policy was requested but not provided.