

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245501	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024
NAME OF PROVIDER OR SUPPLIER Benedictine Living Community of St. Peter		STREET ADDRESS, CITY, STATE, ZIP CODE 1907 Klein Street St Peter, MN 56082	
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50764</p> <p>Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R65) reviewed who was observed to have medications at the bedside, had been appropriately assessed and deemed appropriate to self-administer medications.</p> <p>Findings include:</p> <p>R65's Admission Record printed 10/30/24, identified diagnoses including cerebral infarction (stroke), muscle weakness, chronic kidney disease, and vascular dementia.</p> <p>R65's admission Minimum Data Set (MDS) assessment dated [DATE], identified admitted [DATE], moderately impaired cognition, impairment to both upper and lower extremities, dependent on staff for personal hygiene and transfers.</p> <p>R65's care plan dated 9/22/24, included goals of maintaining general orientation to person, place, and time, receiving appropriate assistance with business matters and decisions, and no adverse reactions to medications.</p> <p>R65's Physician's Order Report printed 10/30/24, identified an order for Artificial Tears 0.1%-0.3% (eye lubricant), one drop to both eyes twice per day.</p> <p>During observations on 10/28/24 at 2:33 p.m., and 7:09 p.m., 10/29/24 at 9:10 a.m., 1:05 p.m., and 3:43 p.m., an individual bottle of Systane eye drops (eye lubricant) was on top of R65's bedside table and within reach of R65, who was present in his bed.</p> <p>During interview on 10/29/24 at 3:45 p.m., registered nurse (RN)-D stated R65 did not have an order for self-administration of medications listed in his chart and should not have had Systane eye drops in his room without a physician's order for self-administration.</p> <p>During interview on 10/29/24 at 4:02 p.m., registered nurse (RN)-A, also known as nurse manager, stated she expected Systane eye drops to be in the medication cart, and they should not have been in R65's room without an assessment and order for self-administration of medications. RN-A further stated R65 did not have an assessment completed or a physician's order for self-administration of medications and the Systane eye drop should have been removed from the room.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 245501
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 10/30/24 at 12:24 p.m., director of nursing (DON) stated she would expect an assessment completed for self-administration of medication and a physician's order for self-administration prior to medications being left in R65's room. DON further stated an assessment should have been completed to ensure R65 was safe to have medications at bedside.</p> <p>Facility Self-Administration of Medications policy and procedure undated, included:</p> <p>Residents have the right to self-administer medications if the interdisciplinary team has determined it is clinically appropriate and safe. The nurses will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. Assessment is documented in the electronic medical record (EMR).</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50761</p> <p>Based on observation, interview, and document review the facility failed to provide treatment/services to maintain optimal visual abilities for 1 of 1 resident (R2) reviewed for vision.</p> <p>Findings include:</p> <p>R2's diagnoses included dizziness and giddiness, anemia, and type 2 diabetes.</p> <p>R2's admission minimum data set (MDS) dated [DATE], indicated adequate vision with glasses or other visual appliances and R2 has corrective lenses (contacts, glasses, or magnifying glass).</p> <p>R2's care plan dated 9/12/24, indicated R2 will be provided adaptive equipment/materials as needed for effective communication.</p> <p>On 10/28/24 at 11:31 a.m., during observation R2 was not wearing eyeglasses.</p> <p>On 10/29/24 at 9:14 a.m., during observation R2 was not wearing eyeglasses.</p> <p>On 10/28/24 at 11:32 a.m., during interview R2 stated eyeglasses need to be adjusted since they keep sliding down R2's nose. R2 stated staff were notified at the end of September and the eyeglasses have not been adjusted.</p> <p>On 10/29/24 at 9:15 a.m., during interview NA-A stated R2 does wear glasses and R2 asked for them to be adjusted. NA-A stated R2's concern was discussed with the unit manager a while ago and unsure if R2's glasses were ever adjusted.</p> <p>On 10/29/24 at 9:24 a.m., during interview licensed practical nurse (LPN)-B stated she is not sure if R2 wears glasses but did mention last week that R2 would like the eyeglasses fixed. R2 mentioned to LPN-B that R2 wanted to have eyeglasses adjusted and LPN-B told R2 she would inquire how to get the glasses adjusted. LPN-B stated eyeglasses need to be adjusted outside the facility. LPN-B stated she informed R2 that he needs an outside appointment, and the RN case managers helps with coordinating appointments.</p> <p>On 10/29/24 11:01 a.m., during interview registered nurse (RN)-A stated she was made aware that R2's eyeglasses need to be adjusted and stated, I might have just forgot about it. RN-A stated she will help coordinate an appointment and transportation to have R2's eyeglasses adjusted.</p> <p>A facility policy addressing vision/eye glasses needs was requested but not received.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614</p> <p>Based on document review and interview, the facility failed to identify diagnoses/indication for use of medications for 5 of 5 residents (R37, R48, R59, R67, R42) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>R37's admission MDS dated [DATE], indicated moderately impaired cognition, required substantial/maximal assistance with personal hygiene, and had behaviors including significantly disrupting the environment, wandering, verbal and physical behaviors.</p> <p>R37's care plan dated 9/26/24, indicated a potential to experience pain/discomfort but currently denies pain. An alteration in mood/behavior/symptoms related to new admission, dementia, anxiety, depression psychotic disturbance, aphasia, delirium, accusatory statements, pushing/pulling;throwing environmental objects at peers and staff, refusal of care. An additional plan of care indicated R37 receives psychotropic medications, antixolytic, antidepressant and antipsychotic medication.</p> <p>R37's Physician Order Report dated 9/25/24 - 11/25/24, included the following medications but lacked indication for use or diagnosis:</p> <ul style="list-style-type: none"> - acetaminophen [OTC] tablet, 500 mg twice a day - aspirin tablet delayed release 81 mg oral once a morning - atorvastatin 40 mg at bedtime - magnesium oxide 250 mg at bedtime - metoprolol tartrate 25 mg twice a day <p>R37's Medication Administration Record (MAR) also lacked indication for use and administration of above medications.</p> <p>50764</p> <p>R48's admission MDS assessment dated [DATE], indicated severe cognitive impairment, required substantial/maximal assistance with dressing and toileting, partial/moderate assistance with bathing and personal hygiene, and diagnoses of renal failure, diabetes, arthritis, and dementia.</p> <p>R48's care plan dated 10/29/24, indicated psychotropic medications which placed R42 at risk for adverse reactions with interventions of attempting gradual dose reductions, non-pharmacological interventions, and monitoring for side effects.</p> <p>R48's Physician Order Report printed 10/30/24, included the following medications that lacked indication for use or diagnosis:</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-acetaminophen tablet, 500 mg four times per day</p> <p>-aspirin tablet, 81 mg daily</p> <p>-atorvastatin tablet, 20 mg daily</p> <p>-dapagliflozin propanediol tablet, 5 mg daily</p> <p>-donepezil tablet, 5 mg daily at bedtime</p> <p>-famotidine tablet, 40 mg daily at bedtime</p> <p>-ferrous sulfate tablet, 65 mg daily</p> <p>-finasteride tablet, 5 mg daily</p> <p>-Humalog KwikPen, 8 units three times per day</p> <p>-Lantus Insulin, 50 units at bedtime</p> <p>-meclizine tablet, 25 mg as needed</p> <p>-metformin tablet, 1000 mg twice per day</p> <p>-metoprolol tartrate tablet, 12.5 mg twice per day</p> <p>-Miralax, 17 gram daily</p> <p>-multivitamin tablet, daily</p> <p>R48's Medication Administration Record (MAR) also lacked indications for use and diagnoses for above medications.</p> <p>R59's quarterly MDS assessment dated [DATE], indicated no cognitive impairment, impairment of upper and lower extremities, use of wheelchair, substantial/maximal assistance with toileting, bathing, dressing, transfers, and diagnoses of dementia and Parkinson's disease.</p> <p>R59's care plan printed 10/30/24, indicated high risk medications placing R59 at risk for adverse reactions. Interventions included administering medications per physician order, observing for side effects of medications, and reporting indications of intolerance.</p> <p>R59's Physician Order Report printed 10/30/24, included the following medications that lacked indication for use or diagnosis:</p> <p>-acetaminophen tablet, 1000 mg three times per day</p> <p>-bisacodyl suppository, 10 mg as needed</p> <p>(continued on next page)</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-carbidopa-levodopa tablet, 25-100 mg three times per day</p> <p>-ketoconazole 2% shampoo, one time per week</p> <p>-Miralax, 17 gram daily</p> <p>-morphine solution, 5 mg every four hours as needed</p> <p>-Senna Plus tablet, 8.6-50 mg daily at bedtime</p> <p>R59's Medication Administration Record (MAR) also lacked indications for use and diagnoses for above medications.</p> <p>R67's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated moderately impaired cognition, use of wheelchair, partial/moderate assistance with bathing, toileting, dressing, and diagnoses of hypertension (high blood pressure), renal failure, and dementia.</p> <p>R67's care plan printed 10/30/24, indicated psychotropic medications which placed R67 at risk for adverse reactions. Interventions included administering medication per physician's orders, monitoring for antipsychotic side effects, attempting gradual dose reductions, and attempting non-pharmacological interventions.</p> <p>R67's Physician's Order Report printed 10/30/24, included the following medications that lacked indication for use or diagnosis:</p> <p>-acetaminophen tablet, 500 mg three times per day and 1000 mg at bedtime</p> <p>-amlodipine tablet, 2.5 mg daily</p> <p>-aspirin tablet, 81 mg daily</p> <p>-carvedilol tablet, 3.125 mg twice per day</p> <p>-Senna-S tablet, 8.6-50 mg daily</p> <p>R67's Medication Administration Record (MAR) also lacked indications for use and diagnoses for above medications.</p> <p>44630</p> <p>R42's quarterly Minimum Data Set (MDS) dated [DATE], indicated severe cognitive impairment, required substantial/maximal assistance with personal hygiene, and diagnoses of Alzheimer's disease and atrial fibrillation (heart arrhythmia).</p> <p>R42's care plan dated 10/29/24, indicated high risk medications which place R42 at a high risk for adverse reactions: anticoagulant (blood thinner); administer anticoagulant as ordered by MD/NP (medical doctor/nurse practitioner)</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R42's Physician Order Report dated 9/30/24-10/30/24, indicated warfarin (blood thinning medication) tablet; 2.5 mg (milligram), once an evening and lacked diagnosis or indication for use.</p> <p>R42's Medication Administration Record (MAR) dated 10/1/24-10/30/24, indicated warfarin tablet 2.5 mg once an evening, and lacked diagnosis or indication for use.</p> <p>On 10/30/24 at 10:05 a.m., director of nursing (DON) stated resident's medications were expected to have a indication or diagnosis on the MAR and provider orders to ensure staff knew the indication for the medication. The DON confirmed R42's MAR and physician orders lacked diagnosis or indication for the warfarin.</p> <p>On 10/30/24 at 11:04 a.m., the consulting pharmacist (CP)-C stated the provider was responsible to attach a diagnosis to the medication order, and stated if a medication order did not have a diagnosis the facility should contact the provider. CP-C stated an indication for each medication was expected in the electronic medical record (EMR) for each medication order.</p> <p>The facility Administering Medications policy dated 8/31/23, indicated To ensure safe administration of resident's medication as indicated and ordered by the provider. Policy: To administer resident medications in a safe and accurate manner that will ensure the 6 rights of patient indication for administration.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614</p> <p>Based on document review and interview, the facility failed to identify diagnoses/indication for use of medications for 2 of 5 residents (R37, R59, R67) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>R37's admission MDS dated [DATE], indicated moderately impaired cognition, required substantial/maximal assistance with personal hygiene, and had behaviors including significantly disrupting the environment, wandering, verbal and physical behaviors.</p> <p>R37's care plan dated 9/26/24, indicated a potential to experience pain/discomfort but currently denies pain. An alteration in mood/behavior/symptoms related to new admission, dementia, anxiety, depression psychotic disturbance, aphasia, delirium, accusatory statements, pushing/pulling;throwing environmental objects at peers and staff, refusal of care. An additional plan of care indicated R37 receives psychotropic medications, antixolytic, antidepressant and antipsychotic medication.</p> <p>R37's Physician Order Report dated 9/25/24 - 11/25/24, included the following psychotropic medications but lacked indication for use or diagnosis except quetiapine:</p> <ul style="list-style-type: none"> - buspirone 5 mg tablet twice a day - quetiapine 50 mg once a morning for delusional disorder <p>R37's Medication Administration Record (MAR) also lacked indication for use and administration of above medications</p> <p>50764</p> <p>R59's quarterly MDS assessment dated [DATE], indicated no cognitive impairment, impairment of upper and lower extremities, use of wheelchair, substantial/maximal assistance with toileting, bathing, dressing, transfers, and diagnoses of dementia and Parkinson's disease.</p> <p>R59's care plan printed 10/30/24, indicated high risk medications placing R59 at risk for adverse reactions. Interventions included administering medications per physician order, observing for side effects of medications, and reporting indications of intolerance.</p> <p>R59's Physician Order Report printed 10/30/24, included the following medications that lacked indication for use or diagnosis:</p> <ul style="list-style-type: none"> -sertraline tablet, 125 mg daily at bedtime <p>R59's Medication Administration Record (MAR) also lacked indications for use and diagnoses for above medications.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R67's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated moderately impaired cognition, use of wheelchair, partial/moderate assistance with bathing, toileting, dressing, and diagnoses of hypertension (high blood pressure), renal failure, and dementia.</p> <p>R67's care plan printed 10/30/24, indicated psychotropic medications which placed R67 at risk for adverse reactions. Interventions included administering medication per physician's orders, monitoring for antipsychotic side effects, attempting gradual dose reductions, and attempting non-pharmacological interventions.</p> <p>R67's Physician's Order Report printed 10/30/24, included the following medications that lacked indication for use or diagnosis:</p> <ul style="list-style-type: none"> -buspirone tablet, 5 mg twice per day -Lexapro tablet, 20 mg daily <p>R67's Medication Administration Record (MAR) also lacked indications for use and diagnoses for above medications.</p> <p>On 10/30/24 at 10:05 a.m., director of nursing (DON) stated resident's medications were expected to have a indication or diagnosis on the MAR and provider orders to ensure staff knew the indication for the medication.</p> <p>On 10/30/24 at 11:04 a.m., the consulting pharmacist (CP)-C stated the provider was responsible to attach a diagnosis to the medication order, and stated if a medication order did not have a diagnosis the facility should contact the provider. CP-C stated an indication for each medication was expected in the electronic medical record (EMR) for each medication order.</p> <p>The facility Administering Medications policy dated 8/31/23, indicated To ensure safe administration of resident's medication as indicated and ordered by the provider. Policy: To administer resident medications in a safe and accurate manner that will ensure the 6 rights of patient indication for administration.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50764</p> <p>Based on observation, interview, and document review, the facility failed to ensure residents were free of significant medication errors for 1 of 8 residents (R15) reviewed for medication administration.</p> <p>Finding include:</p> <p>R15's Face Sheet printed 10/30/24, indicated diagnoses of unspecified dementia, muscle weakness, anxiety disorder, and essential primary hypertension (high blood pressure).</p> <p>R15's quarterly Minimum Data Set (MDS) dated [DATE], indicated severely impaired cognition, use of a wheelchair, and substantial assistance required for dressing, bathing, and hygiene.</p> <p>R15's care plan printed 10/30/24, indicated self-care deficit related to dementia with goal of maintaining current abilities and safety.</p> <p>R15's physician's orders dated 10/29/24, indicated an order for metoprolol succinate tablet extended release 25 mg tablet (blood pressure medication) daily for high blood pressure.</p> <p>During observation on 10/29/24 at 8:02 a.m., trained medication aide (TMA)-A prepared medications for administration to R15. TMA-A crushed acetaminophen 500 mg tablets, escitalopram 15 mg tablet, magnesium 400 mg tablet, senna-docusate 50-8.6 mg tablet, and metoprolol succinate extended release 325mg tablet for ease of swallowing for R15.</p> <p>During interview on 10/29/24 at 8:05 a.m., prior to administration of medication to R15, TMA-A verified she had been crushing R15's metoprolol succinate extended release tablet for quite some time due to R15's difficulty swallowing multiple pills and intended to administer metoprolol succinate tablet crushed. TMA-A further verified there was no order to crush metoprolol succinate extended release tablet. TMA-A verified with registered nurse (RN)-A that metoprolol succinate extended release tablet could not be crushed and disposed of crushed medication mixture.</p> <p>During interview on 10/29/24 at 8:54 a.m., RN-A stated there should be an order for crushing medications. RN-A stated sometimes staff will start crushing medications without an order due to residents not being able to take them whole. RN-A further stated R15 did not have an order to crush medications and metoprolol succinate extended release tablets should not have been crushed due to medication being extended release.</p> <p>During interview on 10/30/24 at 10:34 a.m., director of nursing (DON) stated metoprolol succinate extended release tablet should not have been crushed and would expect an order to crush medications for R15 if her medications were being crushed.</p> <p>During interview on 10/30/24 at 11:04 a.m., consulting pharmacist (CP)-A stated metoprolol succinate extended release was not expected crushed, and stated crushing of the extended release tablet interferes with the disbursement of the medication and disrupts the medication's intended use.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630</p> <p>Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was completed for 2 of 8 residents (R23 and R127) observed for medication administration.</p> <p>Finding include:</p> <p>R23's admission Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognition, required supervision with personal hygiene.</p> <p>R23's care plan dated 9/4/24, indicated staff to apply gloves and gowns prior to facility-identified high-contact care activities, discard PPE in designated location following activities, and sanitize hands after PPE removal.</p> <p>R127's face sheet dated 10/30/24, indicated R127 was admitted [DATE], with diagnoses including left femur (hip) fracture and fracture of shoulder.</p> <p>On 10/28/24 at 7:03 p.m., licensed practical nurse (LPN)-D entered R23's room with eye drops, lidocaine (prevent and to treat pain) bottle, medication cup with apple sauce, and medication cup with a pill. LPN-D placed gloves on both hands and administered R23's eye drops to both eyes, used the lidocaine bottle and rolled on the lidocaine on R23's right shoulder, then placed a pill on the spoon and used apple sauce and administered R23's pill. LPN-D exited the room and walked to the medication storage area, removed gloves, used keys to unlock the medication storage drawers, and returned the eye drops and lidocaine to the medication drawer. LPN-D was further observed to place the medication cup with applesauce and spoon uncovered in the medication drawer. LPN-D stated the applesauce was placed in the drawer to use later for R23's administration of Tylenol. LPN-D was not observed to complete hand hygiene or disinfect hands during or after R23's medication administration. At 7:12 p.m., LPN-D entered the other side of Eagle wing medication area and was observed to prepare R127's medications, and then entered R127's room and failed to complete hand hygiene prior to entering R127's room. LPN-D was observed to hand R127 a medication cup with pills. R127 asked for more water in her water insulated uncovered mug and LPN-D with bare hands grabbed the mug and exited R127's room, entered the dining area and used the water dispenser to place water in the insulated mug, LPN-D reentered R127's room used bare hands and touched the top of the lid to push down the lid and attached the lid to the mug. LPN-D exited the room and walked to the medication storage cabinets and used a sink and washed her hands. LPN-D did not sanitize her hands during the entire medication pass.</p> <p>On 10/28/24 at 7:27 p.m., LPN-D confirmed hand hygiene was not completed during the medication pass with R23 and R127. LPN-C stated it was not her normal process to perform hand hygiene when gloves were used. LPN-A confirmed hand hygiene was expected prior to R127's lid placed on the water mug.</p> <p>On 10/29/24 at 11:58 a.m., registered nurse (RN)-B, known as the nurse manger, stated staff were expected to complete hand hygiene after glove removed and prior to entering or exiting resident's room, and prior to the next medication administration.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245501	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024
NAME OF PROVIDER OR SUPPLIER Benedictine Living Community of St. Peter		STREET ADDRESS, CITY, STATE, ZIP CODE 1907 Klein Street St Peter, MN 56082	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/29/24 at 2:39 p.m., RN-A, known as infection preventionist nurse, and director of nursing (DON) stated staff were expected to perform hand hygiene before and after medication pass, between resident contact, and entering in and out of resident rooms.</p> <p>The facility Hand Hygiene policy dated 9/23, indicated: Infection Prevention begins with the basic hand hygiene. By following proper hand hygiene practices, associates will reduce the spread of potentially deadly germs, as well as reduce the risk of healthcare provider colonization caused by germs acquired from the residents. Times to Perform Hand Hygiene are, but not limited to: Before and after direct resident contact.</p> <p>The facility Administering Medications dated 8/31/23, indicated: Staff follows established infection control procedures for the administration or medications.</p>