



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 7, 2025

Licensee
Benedictine Court
1906 North Sunrise Drive
Saint Peter, MN 56082

RE: Project Number(s) SL30806016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 10, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.

- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEphVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE	
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30806016-0 On April 7, 2025, through April 10, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 45 residents; 39 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 10, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
0 730	Continued From page 4 provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included the required documentation related to hospitalization for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included chronic kidney disease stage 3, and chronic diastolic congestive heart failure. R2's Service Plan dated September 20, 2024, indicated R2 received services including medication administration, mobility assistance as needed, housekeeping, and laundry.	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
0 730	Continued From page 5 R2's progress note dated December 18, 2024, read: "Tenant is out of building in the hospital, evaluation will done upon return." There were no progress notes indicating why and when R3 was admitted to the hospital; nor were there notes indicating when he returned to the licensee. R2's assessment dated January 7, 2025, indicated R2 had been recently hospitalized for MI (myocardial infarction-heart attack) with stent placement. On April 9, 2025, at 3:23 p.m., registered nurse (RN)-C stated R2 had been hospitalized on December 16, 2024, and returned to the licensee on December 24, 2024. RN-C reviewed R2's record and stated it did not reflect circumstances around the hospitalization or when R2 returned to the facility. The licensee's Assisted Living Services - Resident Record policy revised August 1, 2021, indicated: Resident Record Contents: 10. Documentation of incident involving the resident and actions taken in response to the needs of the resident, including pertinent details of the incident. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following:	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
01370	Continued From page 6 (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082		
(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) COMPLETE DATE	
01370	Continued From page 7 licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of two unlicensed personnel (ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired November 22, 2023, to provide direct care services. ULP-F's record lacked evidence of the following education and/or competencies had been completed prior to providing direct cares: - appropriate and safe techniques in personal hygiene and grooming, including: hair care and bathing care of teeth, gums, and oral prosthetic devices care and use of hearing aids dressing and assisting with toileting - standby assistance techniques and how to perform them On April 10, 2025, at 11:51 a.m., licensed assisted living director (LALD)-A stated ULP-F's employee record did not include evidence of the above trainings/competencies, although ULP-F remembered completing them with the registered nurse (RN). LALD-A further stated the nurse who trained ULP-F was no longer employed by the licensee.	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
01370	Continued From page 8 The licensee's Competency Evaluations for Unlicensed Personnel policy revised August 1, 2021, indicated: 1. A Registered Nurse (or other licensed health professional where appropriate) will determine what nursing services may be delegated to properly trained and competency tested ULP. 2. Only ULPs who are determined to be competent and possess the knowledge and skills consistent with the complexity of tasks being delegated will be permitted to perform such delegated tasks. 3. There is an accessible location with current information on ULP and their competencies. 4. Competency evaluations of ULPs will be conducted by a RN, or another instructor may provide the training in conjunction with a RN. 5. Competency evaluations for all ULPs will include: e) Appropriate and safe techniques in personal hygiene and grooming, including: i. hair care and bathing ii. care of teeth, gums, and oral prosthetic devices iii. care and use of hearing aids iv. dressing and assisting with toileting g) Standby assistance techniques and how to perform them 10. A copy of all education, training, and competency testing will be kept in each associates personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
01380	Continued From page 9	01380			
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of two unlicensed personnel (ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082		
(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) COMPLETE DATE
01380	Continued From page 10 ULP-F was hired November 22, 2023, to provide direct care services. ULP-F's employee record lacked documentation of training for the following topics: - safe transfer techniques and ambulation - range of motion and positioning On April 10, 2025, at 11:51 a.m., licensed assisted living director (LALD)-A stated ULP-F's employee record did not include evidence of the above trainings/competencies, although ULP-F remembered completing them with the registered nurse (RN). LALD-A further stated the nurse who trained ULP-F was no longer employed by the licensee. The licensee's Competency Evaluations for Unlicensed Personnel policy revised August 1, 2021, indicated: 1. A Registered Nurse (or other licensed health professional where appropriate) will determine what nursing services may be delegated to properly trained and competency tested ULP. 2. Only ULPs who are determined to be competent and possess the knowledge and skills consistent with the complexity of tasks being delegated will be permitted to perform such delegated tasks. 3. There is an accessible location with current information on ULP and their competencies. 4. Competency evaluations of ULPs will be conducted by a RN, or another instructor may provide the training in conjunction with a RN. 5. Competency evaluations for all ULPs will include: t. Safe transfer techniques and ambulation u. Range of motion and positioning 10. A copy of all education, training, and	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
01380	Continued From page 11 competency testing will be kept in each associates personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
01500	Continued From page 12 and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
01500	Continued From page 13 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired November 22, 2023, to provide direct care services. ULP-F's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - Reporting maltreatment of vulnerable adults On April 10, 2025, at 11:15 a.m., human resources director (HRD)-H reviewed ULP-F's training transcripts for 2024, and stated the above training had not been completed by ULP-F. HRD-H further stated the training should have been automatically assigned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082		
(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) COMPLETE DATE
01620	Continued From page 14 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a change in condition assessment when required for two of three residents (R2, R3), and failed to to ensure ongoing reassessment did not to exceed 90 calendar days from the last assessment, for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
01620	Continued From page 15 R2 R2's diagnoses included chronic kidney disease stage 3 and chronic diastolic congestive heart failure. R2's Service Plan dated September 20, 2024, indicated R2 received services including medication administration, mobility assistance as needed, housekeeping, and laundry. R2's progress note dated December 18, 2024, read: "Tenant is out of building in the hospital, evaluation will be done upon return." There were no progress notes indicating why and when R3 was admitted to the hospital; nor were there notes indicating when he returned to the licensee. R2's assessment dated January 7, 2025, indicated R2 had been recently hospitalized for MI (myocardial infarction-heart attack) with stent placement. R2's previous assessment had been completed September 24, 2024. On April 9, 2025, at 3:23 p.m., registered nurse (RN)-C stated R2 had been hospitalized on December 16, 2024, and returned to the licensee on December 24, 2024. RN-C stated R2 should have had an assessment completed on December 24, 2024, upon return to the licensee. R3 R3's diagnoses included bipolar disorder, chronic kidney disease, hypertension (high blood pressure), arthritis, and pain in right knee. R3's Service Plan dated February 11, 2025, indicated R3 received services including medication administration, assistance with	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
01620	Continued From page 16 compression garment, showering, toileting, housekeeping, and laundry. R3's assessment dated February 11, 2025, indicated R3 was readmitted to the licensee on February 10, 2025, at 1630 (4:30 p.m.) following transfer to acute care hospital on December 25, 2025, followed by the skilled nursing facility. R3's change of condition assessment was completed one day following R3's return from hospitalization/skilled nursing facility. On April 9, 2025, at 3:23 p.m., RN-C stated if a resident returns from hospitalization after 5:00 p.m., he would expect the RN to stay and complete the assessment upon return to the licensee. R4 R4's diagnoses included nontraumatic intracranial hemorrhage (brain bleed), unsteadiness on feet, chronic kidney disease, and atrial fibrillation. R4's Service Plan dated March 12, 2025, indicated R4 received services including medication administration, housekeeping, and laundry. R4's last three assessments were requested. Assessments dated December 10, 2024, March 12, 2025, and April 8, 2025, were provided. 92 days had passed between the December and March assessments, thus exceeding 90 calendar days. On April 9, 2025, at 3:23 p.m., RN-C stated R4's March 12, 2025, assessment had not been completed within 90 days as required. The licensee's Initial and On-Going Assessment	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
01620	Continued From page 17 of Residents policy dated August 1, 2021, indicated: 1. A RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90-days d. Change in resident condition No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one contracted unlicensed personnel (ULP-D)	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082		
(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) COMPLETE DATE
01750	Continued From page 18 completed a competency evaluation for insulin administration by a registered nurse (RN). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was employed by a staffing agency and began providing services for this assisted living provider on January 21, 2025. On April 8, 2025, at 11:45 a.m. ULP-D was observed setting up R6's Novolog FlexPen insulin for administration. ULP-D reviewed R6's medication administration record (MAR), removed the cap from the insulin pen, cleansed the port with an alcohol wipe then applied a needle to the end of the pen. ULP-D then dialed the insulin pen to the prescriber dose and administered to R6. ULP-D did not prime the insulin pen prior to dialing up the prescribed dose. Immediately following the observation, the surveyor asked ULP-D if he had been trained to prime the insulin pen prior to dialing up the dose. ULP-D stated he didn't know about priming the insulin pen as he hadn't received any medication administration training from the licensee as he had his trained medication aide (TMA) certificate. On April 8, 2025, at 2:40 p.m. during a follow-up interview, ULP-D stated on his first day at the facility, the RN gave him a tour and orientation	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
01750	Continued From page 19 related to the job, including showing him that resident medications were kept in a locked cabinet in each apartment. ULP-D stated they went into an apartment of a resident who had insulin; the RN showed him how to prepare and administer the insulin. The RN did not actually administer insulin to the resident as it wasn't time for him to receive it. ULP-D stated he was never observed setting up or administering insulin to a resident by an RN. ULP-D's Pool Staff Orientation Checklist RAs (resident assistants) dated January 21, 2025, lacked initials by the RN for completion of review of insulin pens and insulin administration. On April 8, 2025, at 2:45 p.m., licensed assisted living director (LALD)-A stated she was surprised the RN did not follow up with ULP-D's insulin competency and sign it off. LALD-A further stated they had lost their CNS (clinical nurse supervisor) and RN support nurse; each within a week of ULP-D's orientation. On April 8, 2025, at 2:53 p.m., RN-C stated they train staff to prime the insulin pens with two units prior to dialing up the dosage and would expect this be completed. The licensee's Medication, Treatment, and Therapy Administration - Licensed and Unlicensed Personnel policy revised August 1, 2021, indicated: 1. Training and Competency of ULP: A. A RN instructs the ULP on the following medication administration tasks, according to the resident's service plan, before delegating the task to them: a. The complete procedure of checking a resident's medication administration record	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
01750	Continued From page 20 (MAR) b. The preparation of medication for administration c. The administration of the medication to the resident B. The ULP demonstrates their ability to competently follow the delegated medication administration to the RN. C. Written records, signed by a RN, shall be maintained regarding ULP training and competency testing of delegated medication, treatment, or therapy administration. The licensee's undated, Insulin Pen Competency form indicated: - Twist to remove cap on insulin pen needle, clean rubber stopper with alcohol swab and screw onto pen until need cap meets resistance - Perform 2 unit air shot - Select the dose by turning the dose selector clockwise - Dial the number of units you need to inject No further information was provided. TIME PERIOD FOR CORRECTION: Two days	01750			
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
01790	Continued From page 21 medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
01790	Continued From page 22 (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) trained and ensured competency for one of two employees (unlicensed personnel (ULP)-F) providing medications for residents with unplanned time away from home when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings included: ULP-F was hired November 22, 2023. ULP-F's employee record lacked documentation of competencies for providing medications to residents with medication management who have unplanned time away from home. On April 10, 2025, at 11:51 a.m., licensed	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
01790	Continued From page 23 assisted living director (LALD)-A stated ULP-F's employee record did not include evidence of the above training/competency, although ULP-F remembered completing the training with the registered nurse (RN). LALD-A further stated the nurse who trained ULP-F was no longer employed by the licensee. The licensee's Medication Management - Away from Home policy dated 2021, indicated: 2. Unplanned time away from the community: Attempt to obtain the medications from the resident's pharmacy. When the pharmacy is not able to provide the medications, licensed nurse or unlicensed personnel give the resident/resident's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed five days. a) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: i. The registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; ii. The unlicensed personnel follow the written procedures developed by the registered nurse specifically for unlicensed personnel, including any special instructions or procedures regarding controlled substances. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01890 SS=D	144G.71 Subd. 20 Prescription drugs	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
01890	Continued From page 24 A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were kept in the original container bearing the original prescription label for one of two residents (R2) who received insulin during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included diabetes. R2's Service Plan dated September 20, 2024, indicated the resident received services including medication administration. R2's medication administration record (MAR) dated April 2025, included an order for Novolog FlexPen U-100 insulin 100 unit/ml (units per milliliter) (3 ml) injection. Inject 35 units subcutaneous twice a day.	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
01890	Continued From page 25 On April 9, 2025, at 11:28 a.m., the surveyor observed unlicensed personnel (ULP)-D preparing R2's Novolog insulin pen for administration. Interim clinical nurse supervisor (ICNS)-G was also present. The surveyor noted there was no prescription label on the pen, although it did contain R2's name. ULP-D and ICNS-G each observed the insulin pen and also R2's locked medication cupboard and stated a pharmacy label was not present. ICNS-G stated a pharmacy label should be included with the pen in use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable,	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
01910	Continued From page 26 quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed upon discharge, to document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on April 7, 2025, at 11:16 a.m., registered nurse (RN)-B stated all medications are counted and documented prior to sending with a resident who is discharged. The form is signed by nursing and approved by the provider to be sent with the resident. R1 was admitted to the licensee on July 12, 2024, with diagnoses including chronic kidney disease and history of falling. R1 was discharged from the facility on November 30, 2024. R1's Service Plan dated November 15, 2024, indicated R1 received medication administration. R1's progress note dated December 9, 2024,	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082			
(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) COMPLETE DATE
01910	Continued From page 27 indicated R1's family moved her back home on November 30, 2024. Family returned on December 2, 2024, to obtain R1's medications. A current MAR (medication administration record) was sent with the medications per family request. All medications sent with R1's family member (FM-I). Brand new bubble pack cards were sent as it was the start of cycle fill that day. All cards had 30 pills in them. No controlled substances sent home. R4's record did not include a reconciliation of medications specifying each medication, dose, quantity, or prescription number given to R1's family member upon discharge. On April 8, 2025, at 2:53 p.m., registered nurse (RN)-C stated R1's record did not include evidence the disposition of medications with all required content had been documented prior to sending the medications home with R1's family member. The licensee's Medication Disposal and Med Safe policy dated 2021, indicated: Unused Prescription Drugs: Current unused medications managed by the assisted living will be returned to the pharmacy for credit, or given to the resident or the resident's representative, when the resident's medications are no longer managed by the facility or the medication has been discontinued by the prescriber. Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082		
(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) COMPLETE DATE	
01910	Continued From page 28 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082		
(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) COMPLETE DATE
01940	Continued From page 29 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on April 7, 2025, at 11:16 a.m., registered nurse (RN)-B stated the licensee provided treatment and therapy services to the residents at the facility including simple wound care. R3's provider note dated March 27, 2025, indicated R3 had three stage II pressure ulcers. Two on the left gluteal cleft and one on the right gluteal cleft. The note included orders to apply a Mepilex dressing or substitute; change every three days and as needed for soiling. R3's Medication Administration Record (MAR) dated April 2025, included the following treatment order: Wound Treatment Buttocks bilaterally. Diamora or Mepilex 3 x 3 silicone bordered foam dressing to open areas every three days and PRN (as needed) if soiled.	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082		
(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) COMPLETE DATE
01940	Continued From page 30 R3's record lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. On April 9, 2025, at 3:23 p.m., registered nurse (RN)-C reviewed R3's record and stated it did not include instruction on when to notify a nurse when problems arose with R3's pressure wounds. The licensee's Treatment and Rehabilitative Therapy Management policy revised August 1, 2021, indicated: 1. For each resident receiving individualized management of prescribed treatment or therapy services includes the treatments and therapy plan, a written statement of the treatment or therapy services that will be provided to the resident. 2. The individualized treatment and therapy management record will include the following: d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			



Minnesota Dept. of Health
Division of Environmental Health
Food, Pools, and Lodging
12 Civic Center Plaza
Mankato, MN

Type: Full
Date: 04/10/25
Time: 12:09:25
Report: 1028251040

Food and Beverage Establishment Inspection Report

Page 1

Location:

Benedictine Court
1906 North Sunrise Drive
St Peter, MN56082
Nicollet County, 52

Establishment Info:

ID #: 0038915
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5079348817
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

The interior of the vent hood above the dish machine must be cleaned to remove dust and debris accumulation.

Comply By: 04/10/25

Surface and Equipment Sanitizers

Hot Water: = at 180 Degrees Fahrenheit
Location: Dish Machine - Rinse
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: -10 Degrees Fahrenheit - Location: Norlake - Ambient
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 38 Degrees Fahrenheit - Location: Norlake - Ambient
Violation Issued: No

Type: Full
Date: 04/10/25
Time: 12:09:25
Report: 1028251040
Benedictine Court

Food and Beverage Establishment Inspection Report

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	0	1

This Inspection was conducted in conjunction with HRD.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

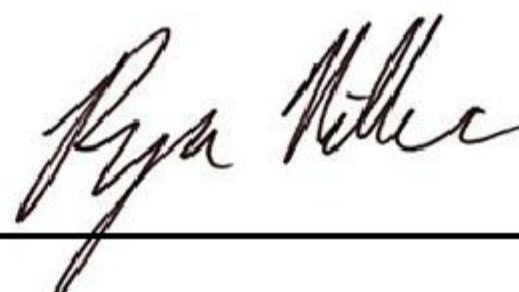
I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028251040 of 04/10/25.

Certified Food Protection Manager Coralyn Stueven

Certification Number: FM44784 Expires: 11/09/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Coralyn Stueven
Food Service Director

Signed:  _____
Ryan Miller
Environmental Health Specialist
MDH - Mankato
507-995-7672
Ryan.Miller@state.mn.us