Electronically Delivered

April 28, 2023

Licensee
Benedictine Living Community Anoka
910 Western Street
Anoka, MN 55303

RE: Project Number(s) SL24353015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 5, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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.

The 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. The 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 and enforcement actions 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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24353	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY ANOKA	910 WESTERN STREET ANOKA, MN 55303

(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 ******ATTENTION****** 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: SL24353015-0 On April 3, 2023, through April 5, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 57 residents; 28 of whom were receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all residents. 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Report, dated April 3, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	0 510		

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0 510	Continued From page 2 national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloving and hand hygiene for one of two unlicensed personnel ((ULP)-E). 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: On April 4, 2023, at 7:22 a.m., the surveyor observed ULP-E don clean gloves without performing hand hygiene. ULP-E then completed blood glucose monitoring for R6 and removed gloves. Without performing hand hygiene, ULP-E applied a new pair of gloves, prepared and administered R6's morning pills, and removed gloves. Without performing hand hygiene, ULP-E applied a new pair of gloves, and while R6 was in bed, ULP-E removed the soiled incontinence	0 510		

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0 510	Continued From page 3	0 510		

brief, provided perineal care, applied a clean brief, then ULP-E removed gloves and performed hand hygiene.

On April 4, 2023, at 9:02 a.m., the surveyor observed ULP-E don clean gloves without performing hand hygiene. ULP-E then assisted R2 with putting on pants, socks, and shoes, then helped stand R2 with the standing lift and transferred R2 to the bathroom. ULP-E removed the feces soiled incontinence brief and lowered R2 to the toilet. Without performing hand hygiene ULP-E removed the soiled linens from R2's bed, placed clean linen on R2's bed, then removed gloves. Without performing hand hygiene ULP-E applied a new pair of gloves, performed perineal care on R2, and removed gloves. Without performing hand hygiene ULP-E applied a new pair of gloves, dressed R2's upper body, brushed R2's hair and beard, and removed gloves. Without performing hand hygiene, ULP-E applied a new pair of gloves, assisted with R2's oral cares, and removed gloves. Without performing hand hygiene, ULP-E applied a new pair of gloves, and obtained R2's blood glucose by use of the freestyle libre 2 sensor system (a blood glucose monitoring system), then sanitized hands.

On April 4, 2023, at 9:51 a.m., ULP-E stated they were trained to change gloves and perform hand hygiene "when you are switching tasks from dirty to clean and wash hands after every resident and if hands get dirty in between."

On April 5, 2023, at 10:09 a.m., clinical nurse supervisor (CNS)-D stated, "Staff are trained initially at orientation and every other staff meeting on gloving and hand hygiene. They should be preforming hand hygiene anytime they

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0 510	Continued From page 4 change tasks or go room to room or anytime they are visibly soiled, changing gloves between cares never wearing gloves from room to room." The Centers for Disease Control (CDC) Hand Hygiene in Health Care Settings Healthcare Providers dated January 8, 2021, directed health care workers to wash their hands immediately before touching a patient [resident], after touching a patient or patient's immediate environment, after glove removal, and when hands were visibly soiled. The licensee's Hand Hygiene policy copywrite dated 2021, read, "Hand washing shall be performed between client [resident] cares and whenever direct physical contact with a client takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: a. Before and after direct contact with a client b. If moving from a contaminated-body site to a clean-body site during client care c. After contact with environmental surfaces or equipment in the immediate vicinity of the client d. After removing gloves or gowns No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780		

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0 780	Continued From page 5 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms in sleeping units. This deficient condition had the ability to affect a limited number of staff and residents. 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). Findings include:	0 780		

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0 780	Continued From page 6 On a facility tour on April 4, 2023, at approximately 11:00 a.m. with licensed assisted living director (LALD)-C and maintenance (M)-F it was observed that smoke alarms were not interconnected so activation of any one alarm activates all alarms in resident rooms 10A and 10B in the lower level of the facility. Smoke alarms are required to be interconnected so activation of one alarm activates all alarms throughout the sleeping unit. This deficient finding was visually verified by LALD-C and M-F at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.	0 800		

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0 800	Continued From page 7 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on April 4, 2023, at approximately 11:00 a.m. with licensed assisted living director (LALD)-C and maintenance (M)-F it was observed the fire rated door did not close and latch in the exit stairway near the Salon. Fire rated doors in exit stairways are required to close and latch as designed and installed. It was observed carbon monoxide alarms were installed and alarm locally in the boiler room only. Carbon monoxide detection and alarms are required to be installed and maintained in accordance with MN Statute. Consult local fire code official regarding the requirements for carbon monoxide detection and alarms. It was also observed the fire rated door did not close and latch in the exit stairway near resident room 317. Fire rated doors in exit stairways are required to close and latch as designed and installed. Storage was observed in the marked means of egress corridor near the boiler room, garage, and resident storage room on the facility tour. Keeping this required means of egress clear of obstructions helps provide access to the exits for occupants and emergency responders during an emergency.	0 800		

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0 800	Continued From page 8 These deficient conditions were visually verified by LALD-C and M-F accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of	0 810		

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0 810	Continued From page 9 the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). A record review of available documentation and interview were conducted on April 4, 2023, at approximately 10:15 a.m. of documents provided by licensed assisted living director (LALD)-C and maintenance (M)-F on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and at least	0 810		

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0 810	Continued From page 10 once every other month as required. All deficiencies were verified by LALD-C and M-F during the interview at approximately 10:45 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) documented instructions for a delegated task in the resident's record for one of one resident (R8) with catheter maintenance. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01420		

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01420	Continued From page 11 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R8 admitted to the licensee on July 16, 2018, under the licensee's former compressive license, and began receiving assisted living services on August 1, 2021. R8's Service Plan with Schedule signed March 7, 2023, indicated R8 received assistance with dressing, oral care, bathing, catheter management, complex medication administration, blood glucose monitoring, laundry, and weekly housekeeping. In addition, staff were to flush catheter leg bag and overnight bag with vinegar / water solution in the morning and evening. On April 4, 2023, at 7:55 a.m., the surveyor observed unlicensed personnel (ULP)-B change R8's overnight catheter bag to the daytime leg catheter bag, empty the overnight catheter bag into the toilet, put vinegar into the overnight catheter bag, drain the vinegar out of the overnight catheter bag into the toilet, and hang the overnight catheter bag in R8's shower. ULP-B did not flush overnight bag with a water and vinegar solution. R8's POC History Report dated April 4, 2023, indicated R8 received special needs care 24 times from March 31, 2023, to April 3, 2023.	01420		

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01420	Continued From page 12 On April 4, 2023, regional director of housing services (RDHS)-G stated on the POC History Report special needs care indicated catheter care was performed and further instruction for special care needs would be located on the service plan which every staff member was able to view. On April 4, 2023, at 8:29 a.m., ULP-B stated they were not trained on how to make the water and vinegar solution to use when rinsing a catheter bag, and the task listed in the software system did not include instructions on how to make the water and vinegar solution. On April 4, 2023, at 1:10 p.m., clinical nurse supervisor (CNS)-D stated they trained staff on catheter maintenance during orientation and the last staff meeting the licensee held included instructions on how to make the water and vinegar solution. In addition, CNS-D stated all service plans that included catheters would contain the instructions listed above however, would lack instruction on how to make the water and vinegar solution. The licensee's Delegation of Nursing Tasks dated March 3, 2022, indicated ULP may perform nursing care service beyond their usual and customary roles by the RN and will perform these tasks under the supervision of a RN. In addition, when needed, the RN would provide written instructions for performing the procedure to the ULP. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24353	A. BUILDING: _____ B. WING _____	04/05/2023

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01710	Continued From page 13	01710		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure the registered nurse (RN) conducted an accurate medication assessment for one of seven residents (R9). 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: R9's diagnoses included major depression, anxiety disorder, Alzheimer's disease with late onset, chronic obstructive pulmonary disease, dizziness, type 2 diabetes, and anemia. R9's Service Plan with Schedule signed January 13, 2023, indicated R9 received assistance with behavior management, hearing aid battery changes, dressing, grooming, meal assistance, medication management, and weekly housekeeping.	01710		

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	24353	A. BUILDING: _____ B. WING _____	04/05/2023

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BENEDICTINE LIVING COMMUNITY ANOKA	910 WESTERN STREET ANOKA, MN 55303

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01710	Continued From page 14 On April 4, 2023, at 8:31 a.m., the surveyor observed one bottle of refresh tears, 30 vials of ipratropium bromide nebulizing solution, one Flovent 220 mcg inhaler, one albuterol sulfate 108 hydrofluoroalkane (hfa) inhaler, and one bottle of vitamin D3 25 mcg with an unknown number of pills in R9's living room unlocked and unsecure. On April 4, 2023, at 8:42 a.m., R9 stated they stored the medications in the living room and self-administered at times when staff were unavailable to assist them with medication administration at the time the medications were needed due to symptoms they experienced. On April 4, 2023, at 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-B set up ipratropium bromide nebulizing solution, hand mouthpiece to R9, turn on nebulizing machine, and exit R7's room while nebulizer treatment was in process. R9's Medication Management Assessment 3.2 dated January 12, 2023, indicated staff administered R9's inhaled medications, oral medications, and eye drops. In addition, medications were kept "locked up". On April 4, 2023, at 8:52 a.m., ULP-B stated R9 was safe to independently administer her own nebulizer and inhalers. On April 5, 2023, at 10:18 a.m., clinical nurse supervisor (CNS)-D stated R9 was able to self-administer medications that were not secured in the apartment. In addition, CNS-D stated they did not accurately document in the assessment that medications listed above were able to be	01710		

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01710	Continued From page 15 self-administered, and in the medication management plan they did not accurately document medications could be stored outside of the locked cabinet. The licensee's Medication Management policy dated August 1, 2021, indicated a RN would conduct a face-to-face assessment with the resident or resident representative to determine medication management services to be provided prior to the start of medication management services and as needed when the resident presents with symptoms or other issues that may be medication related. The assessment would include special administration guidelines of medications to residents. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's	01730		

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	24353	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY ANOKA	910 WESTERN STREET ANOKA, MN 55303

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01730	Continued From page 16 directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a current individualized medication management record with required content for three of seven residents (R7, R8, R9). 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	01730		

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	24353	A. BUILDING: _____ B. WING _____	04/05/2023

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01730	Continued From page 17 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: R7 R7 diagnoses included dementia, psychotic disturbance, mood disturbance, anxiety, major depressive disorder, insomnia, and hypertension. R7's Service Plan Without Schedule signed January 25, 2023, indicated R7 received assistance with medication management and weekly housekeeping. On April 4th, 2023, at 7:29 a.m., the surveyor observed R7 refuse Advair Discus 250 micrograms (mcg) /50 mcg from unlicensed personnel (ULP)-B. R7 stated they had the medication in the bathroom, and they were going to take the medication at later time. The surveyor walked to the bathroom observed Advair Discus 250 mcg / 50 mcg on the top of the bathroom sink. ULP-B documented the refusal of the medication listed above, left the medication on the bathroom sink, and exited the room. R7's Resident Evaluation dated March 29, 2023, indicated R7 required staff to assist with medication storage and preparation. R7's Medication Management Assessment 3.2 dated March 29, 2023, indicated R7 was able to independently administer inhaled medications safely, however nursing managed all medications because R7 missed doses of medications, took excessive doses of medications, or misplaced	01730		

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	24353	A. BUILDING: _____ B. WING _____	04/05/2023

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01730	Continued From page 18	01730		

medications. In addition, R7's medications were kept locked.

R7's medication management record lacked interventions to ensure safety of self-administration and did not accurately reflect how the licensee stored R7's medication listed above.

R8
R8's diagnoses included type 2 diabetes, and pain in the right and left toes.

R8's Service Plan with Schedule signed March 7, 2023, indicated R8 received assistance with dressing, oral care, bathing, catheter management, complex medication administration, blood glucose monitoring, laundry, and weekly housekeeping.

On April 4, 2023, at 8:19 a.m., R8 stated they kept extra insulin in the apartment refrigerator. The surveyor observed the refrigerator held four insulin pens in the butter drawer, unlocked and unsecure. In addition, R8's medications set up by RN and self-administered by R8 were on the kitchen counter.

R8's Resident Evaluation dated February 16, 2023, indicated ULP's assisted and/ or administered medications as delegated by the RN, and staff assisted with storage and preparation of medication and insulin.

R8's Medication Management Assessment 3.2 dated February 16, 2023, indicated R8 received assistance with medication set ups, storing and securing of medications, and coordinating refills. In addition, R8's medications were "locked up" and the nurse completed a medication check

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24353	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY ANOKA	910 WESTERN STREET ANOKA, MN 55303

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01730	Continued From page 19 weekly. R8's medication management record did not accurately reflect how the licensee stored R8's medications. R9 R9's diagnoses included major depression, anxiety disorder, Alzheimer's disease with late onset, chronic obstructive pulmonary disease, dizziness, type 2 diabetes, and anemia. R9's Service Plan with Schedule signed January 13, 2023, indicated R9 received assistance with behavior management, hearing aid battery changes, dressing, grooming, meal assistance, medication management, and weekly housekeeping. On April 4, 2023, at 8:31 a.m., the surveyor observed one bottle of refresh tears, 30 vials of ipratropium bromide nebulizing solution, one Flovent 220 mcg inhaler, one albuterol sulfate 108 hydrofluoroalkane (hfa) inhaler, and one bottle of vitamin D3 25 mcg with an unknown number of pills in R9's living room unlocked and unsecure. On April 4, 2023, at 8:42 a.m., R9 stated they stored and self-administered the medications in the living room and self-administered at times when in case staff were unavailable to assist them with medication administration at the time they the medications were needed due to symptoms they experienced. R9's Medication Management Assessment 3.2 dated January 12, 2023, indicated staff administered R9's inhaled medications, oral medications, and eye drops. In addition,	01730		

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01730	Continued From page 20	01730		

medications were administered by staff and medications were kept "locked up".

R9's medication management record did not accurately reflect how the licensee stored R9's medications.

On April 4, 2023, at 8:52 a.m., the surveyor inquired how ULPs knew which medications needed to be kept in the locked cabinet and which medications could remain out of the locked cabinet. ULP-B stated if medications were not listed on the medication administration record (MAR) they could be kept out and if they had a question on why there was a medication left out, they would contact the nurse for further instruction. In addition, ULP-B stated R9 was safe to independently administer her own nebulizer and inhalers.

On April 4, 2023, at 1:20 p.m., CNS-D stated if the licensee managed the resident's medications, they would be stored in the locked medication cabinet unless it was self-administered. In addition, if refrigeration was needed the medication would be stored in the nursing office refrigerator.

On April 5, 2023, at 10:17 a.m., CNS-D stated R8's insulin should have been stored in the nursing office refrigerator and they believed staff stored insulin in the refrigerator near or in the resident's apartment because it was convenient for them, or staff may have thought insulin needed to be stored in the refrigerator at all times. CNS-D stated R7, R8, and R9 were able to self-administer the medications that were stored out of the locked cabinet in the apartments except for R8's insulin, and R9's medication assessment was not completed accurately for

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	24353	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01730	Continued From page 21 self-administration. In addition, CNS-D stated they did not accurately document in the medication management record which medications could be stored outside of the locked cabinet. The licensee's Medication Management policy dated August 1, 2021, indicated the RN would develop and maintain a current individualized medication management plan for each resident based on resident's assessments. In addition, the individualized medication management record would contain, a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY ANOKA	910 WESTERN STREET ANOKA, MN 55303

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01760	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to manufacturer's instructions for one of two residents (R8) with insulin administration and failed to administer medications according to provider orders for one of seven residents (R6). 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: MANUFACTURER'S INSTRUCTIONS R8's Service Plan with Schedule signed March 7, 2023, indicated R8 received assistance with dressing, oral care, bathing, catheter management, complex medication administration, blood glucose monitoring, laundry, and weekly housekeeping. R8's provider order dated March 20, 2023, included Lantus 22 units (u) subcutaneously daily. On April 4, 2023, at 8:08 a.m., the surveyor observed unlicensed personnel (ULP)-B dial a Lantus Solostar pen (an injectable medication for diabetes) to 2 u. Without pressing on the back of the insulin pen to prime the needle (by ejecting the 2 units), ULP-B dialed the insulin pen to 0 u of	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24353	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01760	Continued From page 23 insulin and then dialed the insulin pen to 22 u of insulin. ULP-B then administered 22 units of insulin to R8's lower left abdomen. On April 4, 2023, at 8:26 a.m., ULP-B stated they were trained by the licensee to prime an insulin pen with 2 u of insulin prior to dialing up the prescribed insulin dose. The surveyor inquired why they did not prime the insulin pen prior to administration on R8. ULP-B stated they believed they did when they dialed the insulin pen however, they did not understand they needed to push the end of the insulin pen to prime the needle. On April 4, 2023, at 1:12 p.m., clinical nurse supervisor (CNS)-D stated ULP's attended a medication class and received a competency on insulin administration. In addition, CNS-D stated ULP's were trained to prime insulin pen with 2 u of insulin prior to dialing prescribed dose. The manufacturer's instruction for the use of Lantus Solostar insulin pen dated June 13, 2022, instructed to prime the pen before each injection, by dialing a test dose of 2 u, tapping the cartridge holder gently to collect air bubbles at the top, and pushing the dose knob until it returns to zero while watching the tip of the needle for a drop or steam of insulin to appear. If no liquid appeared at the tip of the needle the process listed above should be repeated until insulin is seen on the tip of the needle. PROVIDER ORDERS R6's Medication Management Assessment 3.2 dated March 24, 2023, indicated staff administer medications for R6. R6's signed physician order sheet indicated R6	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24353	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
01760	Continued From page 24	01760		

receives Miralax (a laxative solution that increases the amount of water in the intestinal tract to stimulate bowel movements) 17 grams (g) / scoop, take three quarters of a tablespoon in eight ounces of water daily.

On April 4, 2023, at 7:55 a.m., the surveyor observed ULP-E enter R6's room to administer Miralax. ULP-E reviewed R6's medication administration record in the portable handheld phone, then opened the container and poured the medication into the cap that had labeled markings that indicated 8.5 grams or 17 grams for measurements. ULP-E poured an unmeasured amount of the powder into the medication cap. The amount of medication was not significant enough to reach the measurement markings. ULP-E then poured the powder into the glass of water, stirred it, gave the glass to R6 then documented the administration on the handheld phone prior to consumption from R6. ULP-E sanitized their hands and exited R6's room before R6 consumed any of the medication.

On April 4, 2023, at 7:55 a.m., ULP-E was asked about the dosage and how she measured R6's Miralax powder. ULP-E stated, "We are trained to fill the cap up."

On April 5, 2023, at 10:09 a.m., CNS-D stated, "they [staff] should be using a measuring spoon to measure that [Miralax] out." CNS-D also verified there was no documentation that R6 could self-administer medications, or that R6 had been educated on risks and consequences of self-administering medications. CNS-D also stated, "she [R6] really shouldn't be self-administering any of her meds."

The licensee's Medication, Treatment, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24353	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY ANOKA	910 WESTERN STREET ANOKA, MN 55303

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01760	Continued From page 25 Therapy Administration -Licensed and Unlicensed Personnel policy dated March 3, 2023, indicated medications, treatment, or therapy would be administered as directed by the resident's provider orders, the service plan, and medication administration record (MAR). In addition, documentation of a medication reminder, medication assistance, medication administration, treatment, or therapies will be completed immediately after that task has been performed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure prescription medications were stored according to the manufacturer's directions for two of two residents (R2, R8) who received insulin, and failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access for one of seven residents (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	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24353	A. BUILDING: _____ B. WING _____	04/05/2023

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(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
01880	Continued From page 26 resident's health or safety) and was 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: MANUFACTURER'S INSTRUCTIONS R2 On April 4, 2023, at 9:45 a.m., the surveyor observed a mini refrigerator located in a shared hallway outside of R2's room, which contained two NovoLog 100 unit (u) / milliliter (ml) insulin pens and one Basaglar 100 u / ml insulin pen for R2. The mini refrigerator did not contain a thermometer and lacked a temperature log. R8 On April 4, 2023, at 8:19 a.m., the surveyor observed R8's apartment refrigerator which contained four Lantus Solostar pens 100 u / ml. R8's refrigerator did not contain a thermometer and lacked a temperature log. On April 4, 2023, at 8:20 a.m., unlicensed personnel (ULP)-B stated staff do not check refrigerator temperatures in resident's apartments. On April 4, 2023, at 1:20 p.m., clinical nurse supervisor (CNS)-D stated insulin was stored in the butter drawer of the resident's refrigerator unless if the staff managed the insulin, then it should be stored in the nursing refrigerator. In addition, CNS-D stated they did not have a system in place for monitoring refrigeration temperatures in resident rooms. The manufacturer's guidelines for the use of	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24353	A. BUILDING: _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY ANOKA	910 WESTERN STREET ANOKA, MN 55303

(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
01880	Continued From page 27 Novolog insulin pen dated 2023, indicated unused pens should be refrigerated at 36 degrees to 46 degrees Fahrenheit until first use. The manufacturer's guidelines for the use of Basaglar insulin pen dated November 2022, indicated unused pens should be stored in the refrigerator at 36 degrees to 46 degrees Fahrenheit. The manufacturer's instruction for the use of Lantus SoloStar insulin pen dated June 13, 2022, instructed unused Lantus SoloStar pens be stored in a refrigerator between 36 degrees and 46 degrees Fahrenheit until first use. SECURITY OF MEDICATIONS On April 4, 2023, at 9:45 a.m., the surveyor observed a mini refrigerator located in a shared hallway outside of two resident rooms located on the lower level of the facility. The refrigerator held two NovoLog 100 u / ml insulin pens and one Basaglar 100 u / ml insulin pen for R2. The evaluator observed three staff, two visitors, and 5 residents in the area. On April 5, 2023, at 10:17 a.m., CNS-D stated R2's insulin should have been stored in the nursing office refrigerator. In addition, CNS-D stated they believed staff stored insulin in the refrigerator near or in the resident apartment because it was convenient for them, or staff may have thought insulin needed to be stored in the refrigerator at all times. The licensee's Storage of Medications policy dated April 3, 2022, indicated when secured storage of the medication is necessary, the RN will identify where the medication will be stored, how they will be secured or locked under proper	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24353	A. BUILDING: _____ B. WING _____	04/05/2023

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01880	Continued From page 28 temperature control and who has access to the medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs 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 medications were maintained bearing an original prescription label for two of seven residents (R2, R8) and time sensitive medications were dated when opened for one of four residents (R8). In addition, the licensee failed to ensure to discard expired medication for three of seven residents (R2, R10, R11). 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 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).	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24353	A. BUILDING: _____ B. WING _____	04/05/2023

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(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 29 The findings include: EXPIRED MEDICATIONS On April 3, 2023, at 11:00 a.m., the surveyor observed the nursing office medication refrigerator and observed the following expired medications: - R2 five Humolg KwikPen 100 unit (u) / milliliter (ml) with an expiration date of February 2023; - R10 Shingrix vaccine 0.5 ml expired January 25, 2023; and - R11 epinephrine 0.3 milligram (mg) / 0.3 ml expired January 2023. On April 3, 2023, at 11:02 a.m., clinical nurse supervisor (CNS)-D stated nursing normally disposed of expired medications once a month. The licensee's Medication Disposal and Med Safe policy copywrite dated 2021, indicated "Expired medications managed by assisted living will disposed of according to the accepted practices of the Minnesota board of Pharmacy and the labels from the containers will be destroyed." PRESCRIPTION LABEL On April 4, 2023, at 8:19 a.m., the surveyor observed four Lantus Solostar 100 u)/ ml insulin pens in R8's refrigerator and two Lantus Solostar 100 u / ml pens in R8's locked medication cabinet with no resident identifier or prescription label. On April 4, 2023, at 9:45 a.m., the evaluator observed a shared hallway that contained a mini refrigerator outside of R2's room. The evaluator observed two NovoLog 100 u / ml insulin pens and one Basaglar 100 u /ml insulin pen with no	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24353	A. BUILDING: _____ B. WING _____	04/05/2023

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01890	Continued From page 30 resident identifier or prescription label. On April 4, 2023, at 9:51 a.m., unlicensed personnel (ULP)-E stated they knew the insulin belonged to R2 because the mini refrigerator was only used for R2. On April 5, 2023, at 10:09 a.m., CNS-D stated, "All prescription drugs are to have a label on them, I think the issue with the insulin pens is the label is on the box, so we will need to look at a different system for those." TIME SENSITIVE MEDICATION On April 4, 2023, at 8:19 a.m., the surveyor observed one Lantus Solostar insulin pen 100 u / ml in R8's medication cabinet opened without a date open label. On April 4, 2023, at 1:20 p.m., CNS-D stated ULP's were instructed to label insulin pens 30 days from date opened to signify the expiration date. The manufacturer's instruction for the use of Lantus SoloStar insulin pen dated June 13, 2022, instructed to discard Lantus Solostar insulin pen 28 days after opening. The licensee's Storage of Medications policy copywrite dated 2021, read, "until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's name, prescriber's name, date of issue and the name and address of	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01890	Continued From page 31 the licensed pharmacy that issued the medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	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, 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 to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition,	01910		

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01910	Continued From page 32 and names of staff and other individuals involved in the disposition for two of two discharged residents (R1, R5). 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was discharged from the licensee to a skilled nursing facility on October 3, 2022. R1's Medication Administration Record dated October 1, 2022 through October 31, 2022, indicated R1 received potassium chloride extended release (ER) 20 milliequivalent (meq), furosemide 20 milligrams (mg), acetaminophen 500 mg, cyanocobalamin 1000 micrograms (mcg), finasteride 5 mg, furosemide 40 mg, levothyroxine sodium 25 mcg, lidocaine 5 percent (%), metoprolol succinate ER 25 mg, Senna 8.6 mg, Spiriva 18 mcg, vitamin D3 25 mcg, wixela inhub 250 mg-50 mcg inhaler, albuterol sulfate 90 mcg inhaler, nystatin 100000 unit (u) / gram (g), polyethylene glycol 17 g. R1's record lacked a medication disposition to include 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 33 R5 R5 was discharged from the licensee to home on October 27, 2022. R5's Medication Administration Record dated September 1, 2022, through September 30, 2022, indicated R5 received divalproex sodium ER 500 mg, olanzapine 5 mg, olanzapine 7.5 mg, acetaminophen 325 mg, aluminum & magnesium hydroxide-simethicone 200 mg-200 mg-20 mg/5 ml, glucose 40 % gel, loperamide hydrochloride 2 mg, psyllium-calcium capsules, and Senna plus 8.6 mg - 50 mg. R5's record lacked a medication disposition to include 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. On April 5, 2023, at 10:09 a.m., clinical nurse supervisor (CNS)-D, stated "If we manage their medications, we will document that we sent the meds home with them. We do not do documentation of dose. If we destroyed the medication, we put in the documentation with the strength and the pill counts." The licensee's Medication Disposal and Med Safe policy copywrite dated 2021, indicated "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	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 34 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." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *04/03/23*
Time: 11:00:00
Report: 1031231073

Food and Beverage Establishment Inspection Report

Location:
Benedictine of Anoka
910 Western Street
Anoka, MN55303
Anoka County, 02

Establishment Info:
ID #: 0038292
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634214011
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.

4-100 Equipment Construction Materials

4-101.11BCDE

MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.

2 SPATULAS AND 1 TONGS FOUND WITH PLASTIC MELTED/DAMAGED/LOOSE. ***ITEMS DISCARDED*** REMOVE FROM SERVICE ALL DAMAGED UTENSILS THAT ARE UNCLEANABLE OR MAY CAUSE PHYSICAL CONTAMINATION. - COS

Comply By: 04/03/23

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

CAULKING MISSING FROM SOIL TABLE. REMOVE ANY OLD SILICONE AND RESEAL WITH 100% SILICONE (WATER RESISTANT SILICONE) TO COMPLY WITH ABOVE RULE.

Comply By: 04/18/23

4-600 Cleaning Equipment and Utensils

4-602.13

MN Rule 4626.0855 Clean all non-food-contact surfaces of equipment at a frequency necessary to preclude accumulation of soil residues.

TOPS OF 2 KNIFE HOLDERS FOUND WITH TACKY SUBSTANCE ON TOP OF HOLDER. REMOVE HOLDERS AND WASH.

Comply By: 04/10/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: Sanitizer Dispenser
Violation Issued: No

Quaternary Ammonia: = 150 at Degrees Fahrenheit
Location: Sanitizer Bucket (FOH)
Violation Issued: No

Hot Water: = at 169 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Milk
Temperature: 37 Degrees Fahrenheit - Location: Milk Dispenser (FOH)
Violation Issued: No

Process/Item: Cold Hold/Ranch
Temperature: 39 Degrees Fahrenheit - Location: Norlake Cooler (FOH)
Violation Issued: No

Process/Item: Cold Hold/Tomatoes; Sliced
Temperature: 40 Degrees Fahrenheit - Location: Norlake Cooler (cook line)
Violation Issued: No

Process/Item: Cold Hold/Chicken; Raw
Temperature: 36 Degrees Fahrenheit - Location: Walk-in Cooler
Violation Issued: No

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

Inspection conducted by Chris F (MDH).

All violations discussed with Mark after inspection.

Discussed:
- Illness and illness log
- Facilities upkeep and maintenance

NOTIFY INSPECTOR OF ADDITIONS OR CHANGES TO THE BUILDING, MAJOR EQUIPMENT ADDITIONS, OR CHANGES OF EQUIPMENT DUE TO A MENU CHANGE. THESE ACTIONS MAY REQUIRE A REMODEL PLAN REVIEW.

***ANY CUSTOMER COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Environmental Health inspection report number 1031231073 of 04/03/23.

Certified Food Protection Manager: Mark L Anderson

Certification Number: FM52103 Expires: 03/12/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Mark L Anderson
Person in Charge

Signed: _____

Chris Foster
Public Health Sanitarian I
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us

Report #: 1031231073

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul

No. of RF/PHI Categories Out	0	Date	04/03/23
No. of Repeat RF/PHI Categories Out	0	Time In	11:00:00
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Benedictine of Anoka	910 Western Street	Anoka, MN	55303	7634214011

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038292		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	(IN) OUT	PIC knowledgeable; duties & oversight		
2	(IN) OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	(IN) OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN) OUT	Proper use of reporting, restriction & exclusion		
5	(IN) OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT (N/O)	Proper eating, tasting, drinking, or tobacco use		
7	(IN) OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	(IN) OUT N/O	Hands clean & properly washed		
9	(IN) OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN) OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	(IN) OUT	Food obtained from approved source		
12	IN OUT N/A (N/O)	Food received at proper temperature		
13	(IN) OUT	Food in good condition, safe, & unadulterated		
14	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	(IN) OUT N/A N/O	Food separated and protected		
16	(IN) OUT N/A	Food contact surfaces: cleaned & sanitized		
17	(IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A (N/O)	Proper cooking time & temperature		
19	IN OUT N/A (N/O)	Proper reheating procedures for hot holding		
20	IN OUT N/A (N/O)	Proper cooling time & temperature		
21	IN OUT N/A (N/O)	Proper hot holding temperatures		
22	(IN) OUT N/A	Proper cold holding temperatures		
23	(IN) OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A (N/O)	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	(IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT (N/A)	Food additives: approved & properly used		
28	(IN) OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	(IN) OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49	X	Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 04/04/23

Inspector (Signature)