



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 21, 2026

Licensee

Benedictine Living Community | Red Wing
135 Pioneer Road
Red Wing, MN 55066

RE: Project Number(s) SL20291016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 22, 2026, 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.

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 . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed

pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

May 21, 2026

Page 3

may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a long horizontal flourish extending to the right.

Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

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

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY RED WIN			STREET ADDRESS, CITY, STATE, ZIP CODE 135 PIONEER ROAD RED WING, MN 55066		
(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: SL20291016-0 On April 20, 2026, through April 22, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 50 residents; 50 receiving services under the Assisted Living Facility with Dementia Care 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

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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

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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) 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 the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 22, 2026, 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

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	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 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 complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing during blood sugar checks by one of two employees (unlicensed personnel (ULP)-E). This had the potential to affect all residents receiving blood sugar checks. 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).	0 510			

Minnesota Department of Health

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0 510	Continued From page 4 The findings include: On April 21, 2026, at 8:43 a.m., the surveyor observed ULP-E prepare R2's glucometer (device that measures the concentration of glucose (sugar) in a person's blood), wiped R2's right thumb with an alcohol prep pad, pricked R2's fingertip with a lancet, squeezed R2's finger and placed a drop of blood onto the test strip. ULP-E did not wear gloves when she checked R2's blood sugar and did not perform hand hygiene after checking R2's blood sugar. On April 22, 2026, at 10:43 a.m., registered nurse (RN)-C stated staff were expected to wear gloves when performing any task that involved blood and bodily fluids. RN-C stated the staff were also expected to perform hand hygiene between tasks and in between resident cares. The licensee's Procedure for Using Gloves policy dated March 3, 2022, indicated gloves are to be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, secretions, feces, or a contaminated item, such as soiled linens or wound dressings. The licensee's Hand Hygiene policy dated March 3, 2023, indicated hand washing shall be performed between resident cares and whenever direct physical contact with a resident takes place. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			

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0 700	Continued From page 5	0 700			
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all residents residing within the facility. 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). The findings include: On April 20, 2026, at 10:33 a.m., the surveyor observed unlicensed personnel (ULP)-E prepare to check R6's blood sugar and administer insulin. ULP-E logged into the laptop and pulled up R6's record, prepared R6's insulin and went to R6 in the dining room. ULP-E left R6's record open on the laptop screen which was visible to others. On April 20, 2026, at 11:08 a.m., the surveyor	0 700			

Minnesota Department of Health

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0 700	Continued From page 6 observed ULP-E prepare to administer medications to R2. ULP-E logged into the laptop and pulled up R2's record, prepared the medications and went to R2's room. ULP-E left R2's record open on the laptop screen which was visible to others. On April 22, 2026, at 10:45 a.m., registered nurse (RN)-C stated all staff were trained to keep resident records confidential and private from any unauthorized individuals. RN-C stated ULP should have minimized the laptop screen when the laptop was not in use. The licensee's Introduction to HIPAA Privacy Policies dated 2024, indicated the licensee will comply with all applicable privacy requirements of HIPAA. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 775			

Minnesota Department of Health

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0 775	Continued From page 7 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm? to the resident) 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 document titled, Physical Environment Inspection Report (PEIR) dated April 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
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) staff 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) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans	0 810			

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0 810	Continued From page 8 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 staff twice per year per shift with at least one evacuation drill every other month. Evacuation of 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 observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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 the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April	0 810			

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0 810	Continued From page 9 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810			
01320 SS=D	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for one of two unlicensed personnel (ULP-E) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01320			

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01320	Continued From page 10 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-E was hired on October 5, 2017, to provide direct care and services to the facility's residents. On April 20, 2026, at 10:39 a.m., the surveyor observed ULP-E administer medications to R1. ULP-E's employee record lacked evidence of training for the following topics: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing resident for the resident and the resident's preferences, cultural background, and family -understanding appropriate boundaries between staff and residents and the resident's family On April 22, 2026, at 10:40 a.m., housing director (HD)-B stated she would review ULP-E's record to make sure the surveyor was provided the most recent training transcript for ULP-E. On April 22, 2026, at 5:12 p.m., HD-B emailed the	01320			

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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
01320	Continued From page 11 surveyor ULP-E's training transcript which did not include the required training as noted above. The licensee's Assisted Living Orientation-ULP Staff policy dated March 3, 2022, indicated ULPs who are not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test: a. documentation requirements for all services provided b. reports of changes in the resident's condition to the supervisor designated by the home care provider d. maintenance of clean and safe environment i. basic nutrition, meal preparation, food safety, and assistance with eating j. preparation of modified diets as ordered by a licensed health professional k. 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 l. awareness of confidentiality and privacy m. understanding appropriate boundaries between staff and residents and the resident's family No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01320			
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in	01330			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01330	Continued From page 12 section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for two of two unlicensed personnel (ULP-E and ULP-F) to include all required content. 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-E ULP-E was hired on October 5, 2017, to provide direct care and services to the facility's residents. On April 20, 2026, at 10:39 a.m., the surveyor	01330			

Minnesota Department of Health

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01330	Continued From page 13 observed ULP-E administer medications to R1. ULP-E's employee record lacked evidence of training for the following topics: -observing, reporting, and documenting of resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -recognizing physical, emotional, cognitive, and developmental needs of the resident ULP-F ULP-F was hired on March 6, 2026, to provide direct care and services to the facility's residents. ULP-F's Resident Assistant Skills Demonstration Test-Out by RN dated March 31, 2026, had a column for "Client Mobility Range of Motion" where the RN would document if ULP-F was trained and passed a competency tested on this area; however, it was left blank. ULP-F's employee record lacked evidence of competency evaluation for the following topics: -range of motion On April 22, 2026, at 10:40 a.m., housing director (HD)-B stated she would review ULP-E's record to make sure the surveyor was provided the most recent training transcript for ULP-E. Clinical nurse supervisor (CNS)-A stated he left the column for range of motion blank on ULP-F's document because he was new to the licensee and was not sure if range of motion was a service the licensee provided. -At 1:22 p.m., licensed assisted living director (LALD)-G stated RN-C had competency tested ULP-F on range of motion; however, had not	01330			

Minnesota Department of Health

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01330	Continued From page 14 documented it in ULP-F's record. On April 22, 2026, at 5:12 p.m., HD-B emailed the surveyor ULP-E's training transcript which did not include the required training as noted above. The licensee's Assisted Living Orientation-ULP Staff policy dated March 3, 2022, indicated ULPs who are not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test: p. observing, reporting, and documenting resident status q. Basic knowledge of body functioning, changes in body functioning, injuries or other observed changes that must be reported to appropriate personnel r. recognizing physical, emotional, cognitive and development needs of the resident The licensee's Competency Evaluations for Unlicensed Personnel policy dated August 1, 2021, indicated competency evaluations for all ULPs will include: u. range of motion and positioning No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the	01620			

Minnesota Department of Health

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01620	Continued From page 15 physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 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. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under	01620			

Minnesota Department of Health

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01620	Continued From page 16 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) conducted timely ongoing nursing assessments for one of four 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 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 was admitted on March 12, 2026, with diagnoses that included diabetes. R2's service plan dated March 12, 2026, indicated R2 received services to include grooming, dressing, bathing, blood sugar checks, continuous positive airway pressure (CPAP) (device designed to keep breathing airways open during sleep) and medication administration. R2's ongoing nursing assessments dated March 12, 2026, and March 27, 2026, were reviewed. The March 27, 2026, assessment was completed 15 days after the date of the previous assessment, thus exceeding 14 calendar days.	01620			

Minnesota Department of Health

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01620	Continued From page 17 On April 22, 2026, at 10:46 a.m., RN-C stated R2's 14-day assessment was completed a day late. The licensee's Initial and On-Going Nursing Assessment policy dated April 22, 2024, indicated an RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. Initial assessment completed before services started c. 14-day assessment: completed up to 14-days after start of services d. Ongoing assessment: completed periodically but no less than very 90-days e. Change in resident condition No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01640	Continued From page 18 for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of four 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 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 was admitted on March 12, 2026, with diagnoses that included diabetes. On April 21, 2026, at 8:40 a.m., the surveyor observed R2 lying in bed with bilateral compression stockings on. Unlicensed personnel (ULP)-E stated the overnight shift assisted R2 with putting the compression stockings on every morning. R2's service plan dated March 12, 2026,	01640			

Minnesota Department of Health

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01640	Continued From page 19 indicated R2 received services to include grooming, dressing, bathing, blood sugar checks, continuous positive airway pressure (CPAP) (device designed to keep breathing airways open during sleep) and medication administration. R2's service plan did not include compression stockings. On April 22, 2026, at 11:11 a.m., registered nurse (RN)-C stated R2's service plan did not include compression stockings. RN-C stated R2 had Tubi-grips that should be worn in place of the compression stockings as they were too small. RN-C stated she would update R2's primary care provider to clarify if R2 should wear Tubi-grips or compression stockings. The licensee's Service Plan policy dated April 22, 2024, indicated a service plan is developed by the RN based upon the uniform assessment. The RN provides a copy and reviews the plan with the resident/resident representative. Upon review the resident/resident representative signs the service plan documenting agreement of the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as	01710			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01710	Continued From page 20 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 two of four residents (R1 and R2) who self-administered medications were assessed for self-administration of medications. 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: R1 R1 was admitted on November 19, 2024, with diagnoses that included diabetes and COPD (chronic obstructive pulmonary disease) (lung disease that restricts airflow, making it hard to breathe). R1's service plan dated November 13, 2025, indicated R1 received services to include medication administration. R1's signed prescriber orders dated October 20, 2025, included the following: -Breztri Aerosphere 160-9-4.8 micrograms (mcg);	01710			

Minnesota Department of Health

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01710	Continued From page 21 two puffs by mouth twice a day (COPD) R1's Medication Management Assessment dated February 9, 2026, indicated staff would administer medications to R1, including inhaled medications. On April 21, 2026, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R1's oral medications. ULP-E handed R1 his Breztri Aerosphere inhaler. R1 removed the inhaler from the box, shook the inhaler and self-administered two puffs. R1 did not rinse his mouth after using the inhaler and ULP-E did not direct R1 to rinse his mouth. R2 R2 was admitted on March 12, 2026, with diagnoses that included diabetes. R2's service plan dated March 12, 2026, indicated R2 received services to include medication administration. R2's signed prescriber orders dated April 13, 2026, included the following: -Increase Novolog to six units three times a day before meals R2's Medication Management Assessment dated April 3, 2026, indicated staff would administer medications to R2, including insulin pens. On April 20, 2026, at 11:10 a.m., the surveyor observed ULP-E put gloves on, swab the port of R2's Novolog insulin pen with an alcohol prep pad, attach the needle to the port, prime and waste two units of insulin, dial the insulin pen to seven units and hand R2 the insulin pen to self-administer. R2 had difficulty holding the	01710			

Minnesota Department of Health

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01710	Continued From page 22 insulin pen against her abdomen and pushing the injection button. When R2 removed the insulin pen from her abdomen the surveyor noted insulin leaking from the injection site. On April 22, 2026, at 10:52 a.m., registered nurse (RN)-C stated the ULP were supposed to administer all medications to R1 and R2, including R1's inhaler and R2's insulin pen. RN-C further stated if a resident had difficulty self-administering any medication the ULP should have notified the nurse so the nurse could assess if self-administration was appropriate. The licensee's Initial and On-Going Nursing Assessment of Residents policy dated March 22, 2024, indicated the comprehensive assessment would include: v. Medication review including OTC (over the counter) medications, prescription medications and supplements including: 1. Reason taken 2. Side effects, contraindications, allergic or adverse reactions 3. Actions to address side effects, contraindications, allergic or adverse reactions 4 Dosage 5. Frequency of use 6. Route administered 7. Resident difficulties taking medications 8. Self-administration vs. other type of administration 9. Resident preferences for taking medications 10. Medication management interventions to prevent drug diversion by the resident or others who have access to medications 11. Instructions to the resident and resident's legal/designated representatives on interventions to manage the resident's medications and prevent diversion	01710			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01710	Continued From page 23 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse 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 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	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01730	Continued From page 24 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 develop an individualized medication management plan with the required content for four of four residents (R1, R2, R3 and R4). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: During the entrance conference on April 20, 2026, at approximately 9:00 a.m., registered nurse (RN)-C stated the licensee provided medication management services to their residents at the facility. RN-C stated medications including controlled medications were stored in medication	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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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
01730	Continued From page 25 carts. R1 R1 was admitted on November 19, 2024, with diagnoses that included diabetes and COPD (chronic obstructive pulmonary disease) (lung disease that restricts airflow, making it hard to breathe). On April 21, 2026, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R1's oral medications. ULP-E handed R1 his Breztri Aerosphere inhaler. R1 removed the inhaler from the box, shook the inhaler and self-administered two puffs. R1's service plan dated November 13, 2025, indicated R1 received services to include medication administration. R1's medication management plan (within the service plan) dated November 13, 2025, indicated the following: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions is listed on the service plan and in the RN assessment. -it is the standard of practice of [corporation name] to store medications in the resident's room with a locked cupboard and utilizing a secondary locked storage system for controlled substances. R1's Medication Management Assessment dated February 9, 2026, indicated the following: -staff would administer medications to R1, including inhaled medications. -services needed based on assessment included storing and securing of medications	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01730	Continued From page 26 R1's medication management plan did not include medication storage in medication carts and self-administration of inhalers. R2 R2 was admitted on March 12, 2026, with diagnoses that included diabetes. On April 20, 2026, at 11:10 a.m., the surveyor observed ULP-E put gloves on, swab the port of R2's Novolog insulin pen with an alcohol prep pad, attach the needle to the port, prime and waste two units of insulin, dial the insulin pen to seven units and hand R2 the insulin pen to self-administer. R2 had difficulty holding the insulin pen against her abdomen and pushing the injection button. When R2 removed the insulin pen from her abdomen the surveyor noted insulin leaking from the injection site. R2's service plan dated March 12, 2026, indicated R2 received services to include medication administration. R2's medication management plan (within the service plan) dated March 12, 2026, indicated the following: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions is listed on the service plan and in the RN assessment. -it is the standard of practice of [corporation name] to store medications in the resident's room with a locked cupboard and utilizing a secondary locked storage system for controlled substances. R2's Medication Management Assessment dated April 3, 2026, indicated the following:	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01730	Continued From page 27 -staff would administer medications to R2, including insulin pens. -services needed based on assessment included storing and securing of medications R2's medication management plan did not include medication storage in medication carts and self-administration of insulin. R3 R3 was admitted on December 8, 2025, with diagnoses that included dementia. On April 20, 2026, at 11:01 a.m., the surveyor observed ULP-E administer medications to R3. R3's service plan dated January 5, 2026, indicated R3 received services to include medication administration. R3's medication management plan (within the service plan) dated January 5, 2026, indicated the following: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions is listed on the service plan and in the RN assessment. -it is the standard of practice of [corporation name] to store medications in the resident's room with a locked cupboard and utilizing a secondary locked storage system for controlled substances. R3's Medication Management Assessment dated March 6, 2026, indicated the following: -services needed based on assessment included storing and securing of medications R3's medication management plan did not include medication storage in medication carts.	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01730	Continued From page 28 R4 R4 was admitted on November 29, 2022, with diagnoses that included hypertension with chronic kidney disease. On April 20, 2026, at 10:44 a.m., the surveyor observed ULP-E administer medications to R4. R4's service plan dated November 13, 2025, indicated R4 received services to include medication administration. R4's medication management plan (within the service plan) dated November 13, 2025, indicated the following: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions is listed on the service plan and in the RN assessment. -it is the standard of practice of [corporation name] to store medications in the resident's room with a locked cupboard and utilizing a secondary locked storage system for controlled substances. R4's Medication Management Assessment dated February 5, 2026, indicated the following: -services needed based on assessment included storing and securing of medications R4's medication management plan did not include medication storage in medication carts. On April 22, 2026, at 10:56 a.m., clinical nurse supervisor (CNS)-A, registered nurse (RN)-C and regional support nurse (RSN)-H reviewed R1, R2, R3, and R4's medication management plans and stated R1 and R2's plans did not include self-administration of medications. RN-C stated	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01730	Continued From page 29 the licensee stored medications in the residents' rooms in the past but for several years now, all medications were stored in the medication carts. RSN-H stated the residents' medication management plans within the service plan did not include the correct medication storage for this facility. The licensee's Medication Management policy dated August 1, 2021, indicated the RN will develop and maintain a current individualized medication management record for each resident based on resident's assessment. The individualized medication management record will contain the following: a. a statement describing the medication management services that will be provided b. a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with manufacturer's directions c. documentation of specific resident instructions relating to the administration of medications d. identification of person responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. identification of medication management tasks that may be delegated to unlicensed personnel f. procedures for associate notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services g. 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 No further information was provided.	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01730	Continued From page 30	01730			
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 the registered nurse documented resident-specific instructions for two of five residents (R1 and R3) whose medication administration was delegated to unlicensed personnel (ULP). 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:	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01750	Continued From page 31 R1 R1 was admitted on November 19, 2024, with diagnoses that included diabetes and COPD (chronic obstructive pulmonary disease) (lung disease that restricts airflow, making it hard to breathe). R1's service plan dated November 13, 2025, indicated R1 received services to include medication administration. R1's signed prescriber orders dated October 20, 2025, included the following: -Breztri Aerosphere 160-9-4.8 micrograms (mcg); two puffs by mouth twice a day (COPD) On April 21, 2026, at 7:45 a.m., the surveyor observed ULP-E administer R1's oral medications. ULP-E handed R1 his Breztri Aerosphere inhaler. R1 removed the inhaler from the box, shook the inhaler and self-administered two puffs. R1 did not rinse his mouth after using the inhaler, and ULP-E did not direct R1 to rinse his mouth. R3 R3 was admitted on December 8, 2025, with diagnoses that included dementia. R3's service plan dated January 5, 2026, indicated R2 received services to include medication administration. R3's signed prescriber orders dated March 27, 2026, included the following order: -diclofenac sodium (Voltaren) 1% gel; apply two grams topically four times a day to affected area (pain)	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01750	Continued From page 32 R3's medication administration record (MAR) dated April 2026, included the following: -diclofenac sodium 1% gel; apply two grams topically four times daily for right shoulder pain On April 20, 2026, at 11:04 a.m., the surveyor observed ULP-E place a quarter sized amount of diclofenac sodium onto her gloved hand and rub it onto R3's right shoulder. The surveyor inquired how ULP-E knew the amount of diclofenac sodium she administered was the two grams as indicated in the MAR. ULP-E stated sometimes the gel comes with a measuring stick to use but R3 didn't have one and she had been doing this for R3 for a long time and just knew how much was needed. On April 22, 2026, at 11:01 a.m., registered nurse (RN)-C stated ULP-E should have instructed R1 to rinse his mouth with water after using his inhaler. RN-C stated ULP-E should have used the measuring stick when administering R3's diclofenac sodium gel and to notify the nurse if the measuring stick could not be located. Breztri Aerosphere instructions for use dated January 2022, indicated rinse mouth with water after the two puffs to reduce your change of getting a fungal infection. The licensee's Medication, Treatment, and Therapy Administration-Licensed and Unlicensed Personnel policy dated April 22, 2024, indicated medications, treatments or therapies will be administered according to the "6 Rights": a. Right person b. Right medication c. Right time d. Right route (by mouth, eye drops, to the skin,	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01750	Continued From page 33 etc.) e. Right dose (how many ml, drops, etc.) f. Right reason Medication, treatment, or therapy will be administered as directed by the resident's provider orders, the service plan and MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of five residents (R1) who received medication management services. This practice resulted in a level two violation (a	01760			

Minnesota Department of Health

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01760	Continued From page 34 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: R1 was admitted on November 19, 2024, with diagnoses that included glaucoma. R1's service plan dated November 13, 2025, indicated R1 received services to include medication administration. R1's signed prescriber orders dated -dorzolamide-timolol 22.3-6.8 milligram (mg)/milliliter(ml) eye drops; Instill one drop in the left eye twice a day (glaucoma) -brimonidine 0.15% eye drops; instill one drop in the left eye twice a day (glaucoma) R1's medication administration record (MAR) dated April 2026, included the following order: -dorzolamide-timolol 22.3-6.8 mg/ml eye drops; Instill one drop in the left eye twice a day (glaucoma) -brimonidine 0.15% eye drops; instill on drop in the left eye twice a day (glaucoma) On April 21, 2026, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R1, which included eye drops. ULP-E removed a bottle of dorzolamide-timolol eye drops from her pocket, put gloves on, directed R1 to tilt his head back and stated she was going to administer one drop	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01760	Continued From page 35 into his right eye. R1 questioned ULP-E if it was his right eye or left. ULP-E stated right eye and administered one drop in R1's right eye. ULP-E stated she had to wait five minutes before she could administer R1's second eye drop (brimonidine). After five minutes ULP-E removed the bottle of brimonidine eye drops from her pocket, put gloves on and told R1 to tilt his head back and that she would administer one drop into his left eye. The surveyor inquired if the eye drops were supposed to be administered in R1's right or left eye. ULP-E stated the left eye and administered one drop into R1's left eye. The surveyor requested that ULP-E review R1's MAR regarding which eye the dorzolamide-timolol eye drop should have been administered into. R1's MAR indicated dorzolamide-timolol should have been administered in the left eye not the right eye. ULP-E explained to R1 that she had administered it in the wrong eye earlier and then administered the dorzolamide-timolol in his left eye as prescribed. On April 22, 2026, at 11:19 a.m., registered nurse (RN)-C stated she expected the ULP to follow the correct procedure for medication administration to ensure medications are administered as prescribed. RN-C stated it the ULP had any questions or concerns regarding a medication they should notify the nurse immediately. The licensee's Medication, Treatment, and Therapy Administration-Licensed and Unlicensed Personnel policy dated April 22, 2024, indicated medications, treatments or therapies will be administered according to the "6 Rights": a. Right person b. Right medication c. Right time d. Right route (by mouth, eye drops, to the skin,	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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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 36 etc.) e. Right dose (how many ml, drops, etc.) f. Right reason Medication, treatment, or therapy will be administered as directed by the resident's provider orders, the service plan and MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication set up included all the required content for one of two residents (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, 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:	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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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
01770	Continued From page 37 During the entrance conference on April 20, 2026, at 9:00 a.m., registered nurse (RN)-C stated the licensee provided medication management services to their residents, including medication set up. R1 was admitted on November 19, 2024, with diagnoses that included diabetes. R1's service plan dated November 13, 2025, indicated R1 received services to include medication administration. R1's service plan did not include medication setup. R1's signed prescriber orders dated October 20, 2025, included the following order: -acetaminophen 500 milligrams (mg); take 1,000 mg by mouth every six hours as needed for pain On April 21, 2026, at 7:12 a.m., the surveyor observed a blue plastic medication strip that was labeled "acetaminophen" for R1 in the top drawer of the medication cart. Unlicensed personnel (ULP)-E stated the medication strip contained R1's PRN (as needed) medication for pain. R1's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration. On April 22, 2026, at 9:13 a.m., registered nurse (RN)-C stated R1 did not have any medication setup services and all PRN medications should be on a medication card within the medication cart. ULP-E unlocked the medication cart for RN-C who confirmed the blue medication strip was for R1 and had PRN acetaminophen in it. RN-C stated she did not know when the	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01770	Continued From page 38 medication was set up in the medication strip and removed it from the cart. RN-C stated R1's record did not include documentation of the medication setup. The licensee's Medication Administration- Weekly Dosage Box Set Up policy dated April 22, 2024, indicated when the licensed nurse has completed setting up the medications, the nurse will document each individual medication that has been set up on the appropriate paper flowsheet. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770			
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 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	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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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
01790	Continued From page 39 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; (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:	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01790	Continued From page 40 Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for one of two unlicensed personnel (ULP)-F providing medications to residents for 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 include: ULP-F was hired on March 6, 2026, to provide direct care and services to the licensee's residents. ULP-F's Resident Assistant Skills Demonstration Test-Out by RN dated March 31, 2026, had a column for "Resident leave of absence (LOA)"/unplanned time away where the RN would document if ULP-F was trained and passed a competency tested on this area, however it was left blank. ULP-F's employee record lacked documentation of training and competencies for unplanned time away when the RN was not available. On April 22, 2026, at 10:42 a.m., clinical nurse supervisor (CNS)-A and RN-C reviewed ULP-F's record and stated ULP-F was trained and competency tested on unplanned time away;	01790			

Minnesota Department of Health

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01790	Continued From page 41 however, it was not documented in ULP-F's record. The licensee's Competency Evaluations for Unlicensed Personnel policy dated August 1, 2021, indicated a copy of all education, training, and competency testing will be kept in each associates personnel file. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
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 all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access. 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) 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).	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01880	Continued From page 42 The findings include: On April 21, 2026, at 7:12 a.m., the surveyor observed unlicensed personnel (ULP)-E removed R1's medication cards and compare each card to the medication order in the electronic medication administration record (EMAR) and place the medications into a medication cup. ULP-E placed the medication cup with the medication in it on top of the medication cart and went to the kitchenette to get thickened water for R1, leaving the medications unattended. ULP-E stated the kitchenette did not have any thickened fluids and called another staff member to bring some to her. ULP-E returned to the medication cart and placed R1's medication back into the medication cart while she waited for another staff member to bring thickened water to the unit. Several residents were in the common area near the medication cart where ULP-E left R1's medications unattended. On April 21, 2026, at 8:29 a.m., the surveyor observed ULP-E prepare R2's medications for administration. ULP-E brought R2's medications and diabetic supplies to R2's room. ULP-E set R2's medications on the bedside table and prepared to check R2's blood sugar. ULP-E did not have all of the supplies needed to check R2's blood sugar and left R2's room to retrieve the required supplies. ULP-E returned to R2's room, checked her blood sugar and administered R2's medications which had been left unattended on R2's bedside table. On April 22, 2026, at 11:07 a.m., clinical nurse supervisor (CNS)-A stated medications should never be left unattended by staff and expected staff to bring the medications with them if they	01880			

Minnesota Department of Health

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01880	Continued From page 43 have to get supplies for medication administration or secure the medications back in the locked medication cart until they were ready to be administered. The licensee's Storage of Medications policy dated February 1, 2025, indicated medications would be stored in a safe manner. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=D	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 time sensitive medications had an opened date for two of two residents (R2 and 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	01890			

Minnesota Department of Health

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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 44 situation has occurred only occasionally). The findings include: On April 20, 2026, at 10:33 a.m., the surveyor observed unlicensed personnel (ULP)-E prepare to administer R6's insulin. ULP-E removed a plastic container from the medication cart that contained R6's diabetic supplies, one Novolog insulin pen and one Lantus insulin pen. The surveyor noted neither insulin pen had an open date on them. On April 20, 2026, at 11:08 a.m., the surveyor observed ULP-E prepare to administer R2's insulin. ULP-E removed a plastic container from the medication cart that contained R2's diabetic supplies, one Novolog insulin pen and one Lantus insulin pen. The surveyor noted neither insulin pen had an open date on them. On April 22, 2026, at 11:10 a.m., registered nurse (RN)-C stated she expected the ULP to document the open date for all insulin pens at the time a new one is first used. The Novolog instructions for use dated February 2023, indicated to throw away all opened Novolog vials after 28 days, even if they still have insulin left in them. The Lantus (insulin Glargine Solostar pen) instructions for use dated December 2020, indicated the insulin pen could be used for 28 days after the initial use of the pen. The licensee's Storage of Medications policy dated February 1, 2025, indicated the drug must be kept in its original container bearing the original prescription label with legible information	01890			

Minnesota Department of Health

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01890	Continued From page 45 stating the prescription number, name of the drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
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	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01940	Continued From page 46 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. This MN Requirement is not met as evidenced by: Based on observation, 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 four residents (R2) with treatments. 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 was admitted on March 12, 2026, with diagnoses that included diabetes. On April 21, 2026, at 8:40 a.m., the surveyor observed R2 lying in bed with bilateral compression stockings on. Unlicensed personnel (ULP)-E stated the overnight shift assisted R2 with putting the compression stockings on every morning. R2's service plan dated March 12, 2026, indicated R2 received services to include grooming, dressing, bathing, blood sugar checks,	01940			

Minnesota Department of Health

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01940	Continued From page 47 continuous positive airway pressure (CPAP) (device designed to keep breathing airways open during sleep) and medication administration. R2's service plan did not include compression stockings. R2's record lacked prescriber orders for compression stockings. R2's record lacked documentation that staff assisted R2 with compression stockings. R2's record lacked a treatment management plan to include the following required content: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -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. On April 22, 2026, at 11:11 a.m., registered nurse (RN)-C stated R2's treatment plan did not include compression stockings. RN-C stated R2 had Tubi-grips that should be worn in place of the compression stockings as they were too small. RN-C stated she would update R2's primary care provider to clarify if R2 should wear Tubi-grips or compression stockings.	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01940	Continued From page 48 The licensee's Treatment and Rehabilitative Therapy Management policy dated August 1, 2023, indicated each resident receiving individualized management of prescribed treatment or therapy services includes the treatments and therapy plan, a written statement or therapy services that will be provided to the resident. The individualized treatment and therapy management record will include the following: a. a statement of the type of services that will be provided b. documentation of specific resident instructions relating to the treatments or therapy administration c. identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services, and e. 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01960	Continued From page 49 Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as prescribed, or to document the reason they were not provided, for two of four residents (R2 and 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 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 R2 was admitted on March 12, 2026, with diagnoses that included diabetes. On April 21, 2026, at 8:40 a.m., the surveyor observed R2 lying in bed with bilateral compression stockings on. Unlicensed personnel	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01960	Continued From page 50 (ULP)-E stated the overnight shift assisted R2 with putting the compression stockings on every morning. R2's service plan dated March 12, 2026, indicated R2 received services to include grooming, dressing, bathing, blood sugar checks, continuous positive airway pressure (CPAP) (device designed to keep breathing airways open during sleep) and medication administration. R2's service plan did not include compression stockings. R2's record lacked prescriber orders for compression stockings. R2's medication administration record and treatment administration record (MAR/TAR) dated April 2026, included the following: -Put Tubi grips on both lower legs in the morning and remove at HS (bedtime). R2's record lacked documentation that staff assisted R2 with compression stockings. R4 R4 was admitted on November 29, 2022, with diagnoses that included hypertension with chronic kidney disease. R4's service plan dated November 13, 2025, indicated R4 received services to include 1500 milliliter (ml) fluid restriction, and meal tray service/delivery. R4's signed prescriber order dated October 20, 2025, included the following: -1500 ml fluid restriction -Fluid Intake every shift	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01960	Continued From page 51 R4's record lacked documentation of R6's fluid intake with restriction of 1500 ml. On April 22, 2026, at 11:12 a.m., registered nurse (RN)-C reviewed R2's record and stated the ULP were documenting that Tubi-grips were applied to R2's lower legs; however, staff were applying compression stockings, not Tubi-grips. RN-C stated the ULP should have notified nursing if the Tubi-grips could not be located, or the reason why they were not applied. RN-C stated the ULP should not apply compression stockings to any residents if it's not indicated for them to do. RN-C stated R4's record lacked documentation of R4's fluid intake/restriction. RN-C stated R4 was enrolled with hospice (end of life care) and did not think the fluid restriction was needed anymore and would request an order for it to be discontinued. The licensee's Treatment and Rehabilitative Therapy Management policy dated August 1, 2023, indicated each treatment or therapy administered will be documented in the resident's record. The documentation must include: -signature and title of person who administered the treatment or therapy -date and time of administration -when treatments or therapies are not administered as prescribed, the reason why it was not administered and any follow-up procedures that were provided to meet resident needs will be documented No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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01970	Continued From page 52	01970			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for two of four residents (R1 and R2) receiving treatments. 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: R1 R1 was admitted on November 19, 2024, with diagnoses that included diabetes and COPD (chronic obstructive pulmonary disease) (lung disease that restricts airflow, making it hard to breathe). R1's service plan dated November 13, 2025,	01970			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY RED WIN			STREET ADDRESS, CITY, STATE, ZIP CODE 135 PIONEER ROAD RED WING, MN 55066		
(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
01970	Continued From page 53 indicated R1 received services to include thrombo-embolic deterrent (TED) stockings (stockings designed to prevent blood clots and decrease swelling in legs) and continuous positive airway pressure (CPAP) (device designed to keep breathing airways open during sleep) management. R1's task history dated April 2026, included the following: -Ted hose/ace/wraps/compression socks-applying and removing/wash at HS (bedtime). Assist to put on in am (morning). Assist to take off HS. Rinse out stockings, towel dry, hang to dry. -C-Pap putting on/removing, washing appliance in morning. Remove/turn off in a.m. Wash and rinse mask, hang to dry. Ensure tank is filled with distilled water at bedtime. Turn on at HS and assist to put on mask, make sure it fits snug around mouth/nose. R1's signed prescriber orders included the following treatment orders: -Compression stockings, bilateral lower legs, order dated February 3, 2025. -CPAP management, order dated November 12, 2024. R1's record did not include a current order within the past 12 months for TED stockings and CPAP. On April 22, 2026, at 11:15 a.m., registered nurse (RN)-C stated R1's record lacked current prescriber orders within the past 12 months for TED stockings and CPAP management. R2 R2 was admitted on March 12, 2026, with diagnoses that included diabetes.	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY RED WIN			STREET ADDRESS, CITY, STATE, ZIP CODE 135 PIONEER ROAD RED WING, MN 55066		
(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
01970	Continued From page 54 On April 21, 2026, at 8:40 a.m., the surveyor observed R2 lying in bed with bilateral compression stockings on. Unlicensed personnel (ULP)-E stated the overnight shift assisted R2 with putting the compression stockings on every morning. R2's service plan dated March 12, 2026, indicated R2 received services to include grooming, dressing, bathing, blood sugar checks, CPAP and medication administration. R2's service plan did not include compression stockings. R2's record lacked documentation that staff assisted R2 with compression stockings. R2's record lacked prescriber orders for compression stockings. On April 22, 2026, at 9:14 a.m., RN-C stated R2's record lacked prescriber orders for compression stockings. The licensee's Treatment and Rehabilitative Therapy Management policy dated August 1, 2023, indicated there must be up-to-date recorded prescriptions for all treatments and therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must	02040			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY RED WIN			STREET ADDRESS, CITY, STATE, ZIP CODE 135 PIONEER ROAD RED WING, MN 55066		
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02040	Continued From page 55 meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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 the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	02040			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY RED WIN			STREET ADDRESS, CITY, STATE, ZIP CODE 135 PIONEER ROAD RED WING, MN 55066		
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02040	Continued From page 56	02040			
	TIME PERIOD FOR CORRECTION: Twenty One (21) days.				
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP)-E administered medication according to policy and accepted standards of practice during insulin 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 was admitted on March 12, 2026, with diagnoses that included diabetes. R2's service plan dated March 12, 2026,	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY RED WIN			STREET ADDRESS, CITY, STATE, ZIP CODE 135 PIONEER ROAD RED WING, MN 55066		
(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
02320	Continued From page 57 indicated R2 received services to include medication administration. R2's signed prescriber orders dated April 13, 2026, included the following: -Increase Novolog to six units three times a day before meals On April 20, 2026, at 11:10 a.m., the surveyor observed ULP-E put gloves on, swab the port of R2's Novolog insulin pen with an alcohol prep pad, attach the needle to the port, prime and waste two units of insulin, dial the insulin pen to seven units and hand R2 the insulin pen to self-administer. R2 had difficulty holding the insulin pen against her abdomen and pushing the injection button. When R2 removed the insulin pen from her abdomen the surveyor noted insulin leaking from the injection site. ULP-E stated she dials an "extra notch" regarding the extra unit of insulin because R2 had trouble holding the insulin pen to her abdomen when self-injecting which caused the insulin to leak out of R2's abdomen. ULP-E stated she wanted to ensure R2 received the full six units and by administering an extra unit, it would make up for the insulin that leaked out. On April 20, 2026, at 2:41 p.m., clinical nurse supervisor (CNS)-A reviewed R2's medication administration record (MAR) and stated it indicated that R2 would receive Novolog six units three times a day before meals. CNS-A stated he expected the staff to follow the order as indicated in the MAR and could never increase the dose of a medication. On April 22, 2026, at 11:19 a.m., registered nurse (RN)-C stated she expected the ULP to follow the correct procedure for medication administration to	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY RED WIN			STREET ADDRESS, CITY, STATE, ZIP CODE 135 PIONEER ROAD RED WING, MN 55066		
(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
02320	Continued From page 58 ensure medications are administered as prescribed. RN-C stated it the ULP had any questions or concerns regarding a medication they should notify the nurse immediately. The licensee's Medication, Treatment, and Therapy Administration-Licensed and Unlicensed Personnel policy dated April 22, 2024, indicated medications, treatments or therapies will be administered according to the "6 Rights": a. Right person b. Right medication c. Right time d. Right route (by mouth, eye drops, to the skin, etc.) e. Right dose (how many ml, drops, etc.) f. Right reason Medication, treatment, or therapy will be administered as directed by the resident's provider orders, the service plan and MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility	02410			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20291	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2026
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02410	Continued From page 59 shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide privacy for one of three residents (R6) during insulin 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: On April 20, 2026, at 10:33 a.m., the surveyor observed unlicensed personnel (ULP)-E prepare R6's Novolog insulin pen for administration. ULP-E brought the insulin pen to R6 who was sitting at the dining room table visiting with another resident and visitor. ULP-E lifted R6's	02410			

Minnesota Department of Health

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02410	Continued From page 60 shirt up and exposed R6's abdomen and administered the insulin. The licensee failed to ensure R6 was provided privacy during insulin administration. On April 22, 2026, at 11:16 a.m., registered nurse (RN)-C stated she expected privacy with insulin administration, especially when exposing R6's abdomen. RN-C stated the staff were trained to administer insulin in the resident's room. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02410			



Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Benedictine Living Community
135 PIONEER ROAD
Red Wing, MN 55066
Goodhue County
Parcel:

Phone:

License Info

License: HFID 20291

Risk:
License:
Expires on:
CFPM: Sarah J Peters
CFPM #: 2798; Exp: 07/10/2028

Inspection Info

Report Number: F8044261122
Inspection Type: Full - Single
Date: 4/22/2026 Time: 9:19:43 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 4-600 Cleaning Equipment and Utensils

4-602.11E *Priority Level: Priority 3 CFP#: 16*

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

COMMENT: Mold in ice machine.

Comply By: 4/22/2026 Originally Issued On: 4/22/2026

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Kassie Marking. Inspection report reviewed on site with Sarah Jane Peters.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Rochester District Office inspection report number F8044261122 from 4/22/2026

Sarah Peters
Culinary Director


Michael DeMars, RS
Public Health Sanitarian 3
michael.demars@state.mn.us



Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Page: 1

Establishment Info

Benedictine Living Community
Red Wing
County/Group: Goodhue County

Inspection Info

Report Number: F8044261122
Inspection Type: Full
Date: 4/22/2026
Time: 9:19:43 AM

Food Temperature: Product/Item/Unit: Milk; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 40.4 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding

Location: Upright Cooler at 33.0 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Cole slaw; **Temperature Process:** Cold-Holding

Location: Walk-in Cooler at 35.5 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding

Location: Walk-in Cooler at 36.0 Degrees F.

Comment:

Violation Issued?: No



Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Benedictine Living Community
Red Wing
County/Group: Goodhue County

Inspection Info

Report Number: F8044261122
Inspection Type: Full
Date: 4/22/2026
Time: 9:19:43 AM

New Record: Product: ; Sanitizing Process:

Location: Equal To

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Lactic Acid; Sanitizing Process: Wiping Cloth Bucket

Location: Kitchen Equal To 704 PPM

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL20291016	Date: 4/20/2026
Facility Name: Benedictine Living Community	
Facility Address: 135 Pioneer Road, Red Wing, MN 55066	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

Comments: There was no carbon monoxide detection provided in the fuel-burning boiler room near the chapel on the second floor or within 10 feet of resident rooms. Facility staff and annual inspection records verified that only one carbon monoxide detector was provided in the facility, and it was located in the basement mechanical room. Carbon monoxide alarms should be provided within 10 feet of resident rooms or carbon monoxide detection connected with the fire protection system should be installed in any areas with fuel-burning appliances.

3. Listed single and multiple-station smoke alarms complying with UL 217 shall be installed. [Minn. Stat. 144G.45 subd. 2; MSFC 907.2.10]

Comments: The majority of smoke alarms installed throughout the facility in resident rooms did not display any indication they were listed to underwriter laborites (UL) standards to comply with requirements. Licensee was unable to provide user manuals or UL listing information to the surveyor during the survey. The online user manual for the smoke alarm model provided did not indicate proper listing to UL standards. No further information was provided to the surveyor, and the requirements for smoke alarms could not be verified. The non-compliant smoke alarms are not approved for operation as

they may not be reliable in event of an emergency and should be replaced with appropriate smoke alarms that conform to UL 217 standards.

4. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

Comments:

The smoke alarms installed in the majority of resident room bedroom hallways throughout the facility did not have the correct power source. Hardwired smoke alarm connections were present in the resident rooms but were covered up with wireless smoke alarms. Hardwired smoke alarms should be installed where hardwired mounting connections are available, and these alarms should be maintained in proper working condition.

The smoke alarm provided in resident room 128 was manufactured in 2002, which is beyond its expiration date. Smoke alarms exceeding 10 years of age should be replaced.

5. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. The path of egress travel to exits and within exits shall be marked by readily visible exit signs to clearly indicate the direction of egress travel in cases where the exit or the path of egress travel is not immediately visible to the occupants. [Minn. Stat. 144G.45 subd. 2; MSFC 1013.1]

Comments: The exit sign leading from the memory care unit leading out to the main lobby area was oriented backwards and did not properly indicate the direction of travel for the egress path. The exit sign was turned in a way where unilluminated back portion of the sign was visible when looking at the exit door from the area. The exit sign should be turned around and maintained in the proper orientation.

6. A stairway in an exit enclosure that continues below the level of exit discharge shall be arranged and marked to make the direction of egress to a public way readily identifiable. Stairs that continue one half story beyond the level of exit discharge need not be provided with barriers where the exit discharge is obvious. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.21]

Comments: The stairwell leading down to the basement level did not have a guard or gate to direct access to the egress path at the level of exit discharge during an emergency. Hardware for a gate was present where a gate had been removed in the stairwell. The gate should be replaced and maintained to direct travel during an evacuation.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments: No site-specific employee actions for fires or similar emergencies were provided to the surveyor during the survey. General fire safety information was provided, but it was not relevant to the facility, was outdated, and was not complete. The FSEP should include site-specific procedures for evacuation during fire or similar emergencies and be maintained so that it is accurate.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

Comments: No specific resident procedures for fires or similar emergencies were provided to the surveyor during the survey. Residents should be provided with site-specific procedures for evacuation during fire or similar emergencies.

3. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

Comments: Licensee provided documentation of staff training upon hire and once a year but was not able to provide any documentation of additional training. Staff should receive site specific training on the FSEP upon hire and twice a year thereafter.

4. 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. [Minn. Stat. 144G.45 subd.2]

Comments: No documentation of resident training on the FSEP was provided to the surveyor during the survey. The licensee indicated that residents were informed of fire safety information at admittance but that no records of such training were kept. Residents should be offered training on procedures for evacuation at least once per year.

☒ TAG IDENTIFICATION: 2040

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and have a safety risk assessment performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm. [Minn. Stat. 144G.81 subd.1]

Comments: The licensee provided a safety risk assessment but did not include assessment or mitigation of identified risks. Documented assessment and mitigation of risks should be provided to ensure proper measures are in place and are being performed to protect residents, staff and visitors from harm.