



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 15, 2023

Licensee
St. Scholastica Convent
1845 20th Avenue Southeast
Saint Cloud, MN 56304

RE: Project Number(s) SL30303015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 27, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

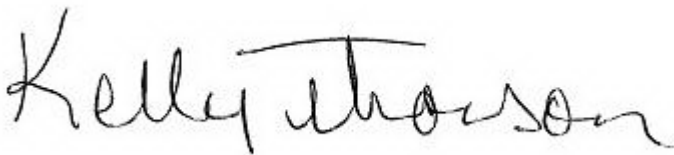
Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink that reads "Kelly Thorson". The signature is written in a cursive, flowing style.

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 651-281-9796

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER ST SCHOLASTICA CONVENT		STREET ADDRESS, CITY, STATE, ZIP CODE 1845 20TH AVENUE SE SAINT CLOUD, MN 56304		
(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: SL30303015-0 On April 24, 2023, through April 27, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 59 residents, all of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=D	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER ST SCHOLASTICA CONVENT		STREET ADDRESS, CITY, STATE, ZIP CODE 1845 20TH AVENUE SE SAINT CLOUD, MN 56304		
(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
0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the daily staffing schedule was posted in a central location in the facility, accessible to staff, residents, volunteers, and the public as required, potentially affecting the licensee's current residents, staff, and any visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER ST SCHOLASTICA CONVENT		STREET ADDRESS, CITY, STATE, ZIP CODE 1845 20TH AVENUE SE SAINT CLOUD, MN 56304		
(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
0 470	Continued From page 2 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread 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: The licensee held an Assisted Living with Dementia Care license, was licensed for a capacity of 72 residents, and at the time of the survey had a census of 59 residents. During a tour of the facility with licensed assisted living director (LALD)-C on April 24, 2023, at 12:30 p.m., the surveyors observed the facility layout to include two resident living areas, including the Angel Wings (unsecure units), with residents on three floors, and the secured dementia unit. The surveyors observed on the staff door to the Angel Wings unit, a white board with three staff names and hours worked, one for each shift. On April 27, 2023, at approximately 9:35 a.m., the medication room in the secured dementia unit was observed with licensed practical nurse (LPN)-H. On the counter below the locked narcotic cupboard, a white board was placed with the staff names, work assignment, and hours working. LPN-H stated this was always kept in the medication room, and a full schedule was posted outside the medication room, behind the computer for residents to see. When the surveyor observed the schedule behind the computer, it was small print and difficult to see while standing. On April 27, 2023, at 11:05 a.m., clinical nurse supervisor (CNS)-A stated the white board with	0 470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER ST SCHOLASTICA CONVENT		STREET ADDRESS, CITY, STATE, ZIP CODE 1845 20TH AVENUE SE SAINT CLOUD, MN 56304		
(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
0 470	Continued From page 3 the staffing posting was kept in the medication room and said the full schedule behind the computer on the unit would be difficult to see from a wheelchair. In addition, CNS-A stated the board in the Angel Wing did not include the secured dementia unit staff. The licensee's Staffing policy dated October 2022 noted the staffing plan would be developed, implemented, and posted that would ensure an adequate number of qualified direct-care staff are available to meet the sister residents' needs 24-hours a day, seven days a week, and would be posted in a central location to ensure accessibility to sister residents, volunteers and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a	0 480		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER ST SCHOLASTICA CONVENT		STREET ADDRESS, CITY, STATE, ZIP CODE 1845 20TH AVENUE SE SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 4 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 included document titled, Food and Beverage Establishment Inspection Report dated April 24, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in	0 780		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER ST SCHOLASTICA CONVENT		STREET ADDRESS, CITY, STATE, ZIP CODE 1845 20TH AVENUE SE SAINT CLOUD, MN 56304		
(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
0 780	Continued From page 5 the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the provisions of the Minnesota State Fire Code and failed to provide smoke alarms in the resident sleeping rooms of Louise Hall. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). Findings include: On a facility tour on April 25, 2023, at approximately 11:50 a.m. with Building Grounds Manager (BGM)-B, observed that Louise Hall did not have smoke alarms installed in all of the resident sleeping rooms. BGM-B verbally confirmed survey staff observations during the facility tour. No further information was provided.	0 780		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER ST SCHOLASTICA CONVENT		STREET ADDRESS, CITY, STATE, ZIP CODE 1845 20TH AVENUE SE SAINT CLOUD, MN 56304		
(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
0 780	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
01440 SS=E	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted supervision of staff performing delegated tasks for two of three employees (unlicensed personnel (ULP)-D, ULP-E). This practice resulted in a level two violation (a	01440		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER ST SCHOLASTICA CONVENT		STREET ADDRESS, CITY, STATE, ZIP CODE 1845 20TH AVENUE SE SAINT CLOUD, MN 56304		
(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
01440	Continued From page 7 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-D ULP-D began employment on June 9, 2022, to provide direct care services to residents of the assisted living with dementia care facility. ULP-D's record lacked evidence an RN conducted direct supervision of ULP-D within 30 days of performing delegated tasks. On April 27, 2023, at 11:30 a.m., clinical nurse supervisor (CNS)-A stated ULP-D did not complete medication administration training until December 2022; however, CNS-A indicated ULP-D was performing other delegated nursing tasks from the time she was hired and should have had direct supervision within 30 calendar days after the date that she began working for the facility. ULP-E ULP-E began employment on February 14, 2022, to provide direct care services to residents of the assisted living with dementia care facility. ULP-E's record lacked evidence an RN conducted direct supervision of ULP-E within 30 days of performing delegated tasks.	01440		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER ST SCHOLASTICA CONVENT		STREET ADDRESS, CITY, STATE, ZIP CODE 1845 20TH AVENUE SE SAINT CLOUD, MN 56304		
(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
01440	Continued From page 8 On April 27, 2023, at 11:32 a.m., CNS-A stated she was unable to find evidence that ULP-E had been directly supervised while performing delegated tasks within 30 days after the date that she began working for the facility. The licensee's Supervision of Licensed and Unlicensed Personnel policy, dated October 2022, indicated direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments, or assigned therapy tasks, must be performed within 30 days after the person began working and had been trained and determined to be competent to perform all the tasks assigned, and thereafter as needed, based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the	01910		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER ST SCHOLASTICA CONVENT		STREET ADDRESS, CITY, STATE, ZIP CODE 1845 20TH AVENUE SE SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 9 medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R5) upon discharge. 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: R5 was discharged to a different facility on September 12, 2022, after receiving services for diagnoses including fractured ribs from a fall, tremors, high blood pressure, arthritis, chronic low back pain, and cerebral infarct (stroke) with new onset memory loss and confusion. R5's Discharge - Transfer Summary, dated September 12, 2022, indicated R5 received services following a left-sided rib fracture and was treated conservatively. The summary included R5 received physical and occupational therapy while at the facility and was independent. In addition, R5 was receiving Tylenol (mild pain reliever) as	01910		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER ST SCHOLASTICA CONVENT			STREET ADDRESS, CITY, STATE, ZIP CODE 1845 20TH AVENUE SE SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
01910	Continued From page 10 needed, wearing a Lidoderm patch (pain reliever) and had tramadol (for moderate pain) as needed. R5's Cozaar (treat high blood pressure) was increased, and blood pressures were improved with the change. R5's Master Care Plan, dated August 22, 2022, indicated R5 needed full medication management and setup and staff would administer all medications as prescribed. R5's Current Medications list in RTasks (electronic medical record), undated, identified the following medications: - aspirin EC (enteric coated) (prevent heart attack/stroke) 81 mg (milligrams) by mouth daily; - calcium carbonate and vitamin D3 (supplement) 600-400 mg/units by mouth daily; - Cozaar 25 mg daily; - lidocaine patch (same as Lidoderm) 4% topical daily; - Lipitor (treat high cholesterol) 20 mg by mouth daily; - acetaminophen (same as Tylenol) 1000 mg by mouth every 6 hours as needed; - Senna S (treat constipation) 8.6 mg/50 mg by mouth twice daily as needed; and - tramadol Hydrochloride 50 mg by mouth every 6 hours as needed. R5's Medication Disposition dated September 12, 2022, included the following: - On September 12, 2022, at 10:21 a.m., tramadol hydrochloride 50 mg, including prescription number and quantity "10," were given to the resident due to discharge from the facility, and listed a staff and a witness to the disposition. R5's record lacked documentation of the disposition of the other medications R5 was	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER ST SCHOLASTICA CONVENT		STREET ADDRESS, CITY, STATE, ZIP CODE 1845 20TH AVENUE SE SAINT CLOUD, MN 56304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 11 taking at the time of discharge, including the quantity of each medication, the prescription number as applicable, and names of staff and other individuals involved in the disposition, as required. On April 27, 2023, at 12:45 p.m., clinical nurse supervisor (CNS)-A stated R5 requested to self-administer medications a few days prior to discharge, and medications were given to R5 at that time with the exception of the lidocaine patches; however, a disposition with the required information was not completed when medication management services were discontinued. CNS-A indicated not being aware of this requirement. The licensee's Discharge Medications policy, dated January 2023, indicated the nurse verified the discharge medications for completeness and accuracy against the physician's orders and the directions for use were reviewed with the resident or responsible party. The policy directed discharge medications were counted or the volume of liquid estimated, and the date, pharmacy name and prescription number, name and strength of each medication, and quantity or amount sent with resident, was entered in the medication record or in the nursing notes by the nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the	02110		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER ST SCHOLASTICA CONVENT		STREET ADDRESS, CITY, STATE, ZIP CODE 1845 20TH AVENUE SE SAINT CLOUD, MN 56304		
(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
02110	Continued From page 12 assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities	02110		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER ST SCHOLASTICA CONVENT		STREET ADDRESS, CITY, STATE, ZIP CODE 1845 20TH AVENUE SE SAINT CLOUD, MN 56304		
(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
02110	Continued From page 13 with dementia care were developed and provided to each resident and the residents' legal and designated representative at the time of move-in. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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: The licensee held an Assisted Living with Dementia Care license effective August 1, 2022. On April 26, 2023, at 10:43 a.m., licensed assisted living director (LALD)-C stated the residents were not provided a copy of the policies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

Type: Full
Date: 04/24/23
Time: 11:50:35
Report: 1037231111

Food and Beverage Establishment Inspection Report

Page 1

Location:

St Scholastica Convent
1845 20th Avenue Se
St Cloud, MN56304
Sherburne County, 71

Establishment Info:

ID #: 0037953
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202512225
ID #:

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

The following orders were issued during this inspection.

3-200A Food Characteristics: approved source

3-201.11A ** Priority 1 **

MN Rule 4626.0130A Remove all foods not obtained from approved sources from the premises.

REMOVE THE HOMEMADE (FROM MONASTERY) REFRIGERATOR PICKLES. ALL FOODS SERVED MUST COME FROM APPROVED SOURCES.

Comply By: 04/24/23

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

AT THE TIME OF INSPECTION, THERE WAS NO TEMPERATURE MEASURING DEVICE FOR THE MECHANICAL HOT WATER DISHWASHER. PROVIDE A WATERPROOF, IRREVERSIBLE REGISTERING TEMPERATURE INDICATOR. DISCUSSED WITH ROB THERMOMETER OPTIONS OR T-STICKS/TEMPERATURE STICKERS.

Comply By: 05/08/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 at Degrees Fahrenheit

Location: 3 COMPARTMENT SINK

Violation Issued: No

Hot Water: = at 164 Degrees Fahrenheit

Location: DISHWASHER

Violation Issued: No

Type: Full
Date: 04/24/23
Time: 11:50:35
Report: 1037231111
St Scholastica Convent

Food and Beverage Establishment Inspection Report

Page 2

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: SLICED TURKEY
Violation Issued: No

Process/Item: Time/Temp (HAACP)
Temperature: 36 Degrees Fahrenheit - Location: SLICED TOMATOES
Violation Issued: No

Process/Item: Display Cooler
Temperature: 38 Degrees Fahrenheit - Location: MILK JUG
Violation Issued: No

Process/Item: Hot Holding
Temperature: 169 Degrees Fahrenheit - Location: BREADED CHICKEN PATTY
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 37 Degrees Fahrenheit - Location: BREAD PUDDING
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 39 Degrees Fahrenheit - Location: PRECOOKED RICE BLEND
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 39 Degrees Fahrenheit - Location: SLICED CANTELOPE
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: LACTOSE FREE MILK
Violation Issued: No

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

Type: Full
Date: 04/24/23
Time: 11:50:35
Report: 1037231111
St Scholastica Convent

Food and Beverage Establishment Inspection Report

Page 3

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

I acknowledge receipt of the inspection report number 1037231111 of 04/24/23.

Certified Food Protection Manager ROBERT M COLUCCI

Certification Number: 108516 Expires: 11/22/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

Establishment Representative

Signed: Michelle L Hovanes

Michelle Hovanes
Public Health Sanitarian
St. Cloud
320-223-7307
michelle.hovanes@state.mn.us

Report #: 1037231111		Food Establishment Inspection Report				
		No. of RF/PHI Categories Out		1	Date	04/24/23
		No. of Repeat RF/PHI Categories Out		0	Time In	11:50:35
		Legal Authority MN Rules Chapter 4626		Time Out		
St Scholastica Convent		Address 1845 20th Avenue Se		City/State St Cloud, MN	Zip Code 56304	Telephone 3202512225
License/Permit # 0037953		Permit Holder		Purpose of Inspection Full	Est Type	Risk Category
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS						
Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item						
Mark "X" in appropriate box for COS and/or R						
IN= in compliance OUT= not in compliance N/O= not observed N/A= not applicable COS= corrected on-site during inspection R= repeat violation						
Compliance Status				COS	R	
Supervision						
1	IN	OUT	PIC knowledgeable; duties & oversight			
2	IN	OUT N/A	Certified food protection manager, duties			
Employee Health						
3	IN	OUT	Mgmt/Staff;knowledge,responsibilities&reporting			
4	IN	OUT	Proper use of reporting, restriction & exclusion			
5	IN	OUT	Procedures for responding to vomiting & diarrheal events			
Good Hygienic Practices						
6	IN	OUT N/O	Proper eating, tasting, drinking, or tobacco use			
7	IN	OUT N/O	No discharge from eyes, nose, & mouth			
Preventing Contamination by Hands						
8	IN	OUT N/O	Hands clean & properly washed			
9	IN	OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate procedure properly followed			
10	IN	OUT	Adequate handwashing sinks supplied/accessible			
Approved Source						
11	IN	OUT	Food obtained from approved source			
12	IN	OUT N/A N/O	Food received at proper temperature			
13	IN	OUT	Food in good condition, safe, & unadulterated			
14	IN	OUT N/A N/O	Required records available; shellstock tags, parasite destruction			
Protection from Contamination						
15	IN	OUT N/A N/O	Food separated and protected			
16	IN	OUT N/A	Food contact surfaces: cleaned & sanitized			
17	IN	OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food			
GOOD RETAIL PRACTICES						
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.						
Mark "X" in box if numbered item is not in compliance Mark "X" in appropriate box for COS and/or R COS= corrected on-site during inspection R= repeat violation						
Safe Food and Water				COS	R	
30	IN	OUT N/A	Pasteurized eggs used where required			
31			Water & ice obtained from an approved source			
32	IN	OUT N/A	Variance obtained for specialized processing methods			
Food Temperature Control						
33			Proper cooling methods used; adequate equipment for temperature control			
34	IN	OUT N/A N/O	Plant food properly cooked for hot holding			
35	IN	OUT N/A N/O	Approved thawing methods used			
36			Thermometers provided & accurate			
Food Identification						
37			Food properly labeled; original container			
Prevention of Food Contamination						
38			Insects, rodents, & animals not present			
39			Contamination prevented during food prep, storage & display			
40			Personal cleanliness			
41			Wiping cloths: properly used & stored			
42			Washing fruits & vegetables			
Food Recalls:						
Person in Charge (Signature)				Date: 04/24/23		
Inspector (Signature)						