Electronically Delivered

September 30, 2022

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

RE: Project Number(s) SL30806015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 31, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines areassessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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 Department of Health within 15 calendar days of the correction order receipt date.

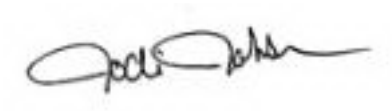
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general 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

Free from Maltreatment reconsideration requests should be addressed 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 this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL#30806015 On August 29, 2022, through August 31, 2022, 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 37 residents; 33 receiving 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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensed assisted living director (LALD)-A was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 29, 2022, at 10:58 a.m., the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-A currently held a LALD license effective through October 31, 2022; however, LALD-A's license lacked an organization listed as the Director of Record for the licensee. On August 31, 2022, at 11:50 a.m., LALD-A reviewed the BELTSS website and confirmed she was not listed as the director of record and further stated she hadn't realized she needed to add that.	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 110	Continued From page 2 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (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	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 3 review, the licensee failed to ensure the staffing schedule was posted 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 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license, was licensed for a capacity of 55 residents and at the time of the survey had a census of 37 residents. The licensee failed to post a current staffing schedule. On August 29, 2022, at 10:28 a.m., during the facility tour with director of nursing (DON)-B, the surveyor observed a bulletin board on the wall outside of the nurses' office. There was a label pinned to the top that stated "daily staffing hours" but the bulletin board was empty. DON-B verified a staff schedule was not posted and stated "since I've been here nothing has been posted there". DON-B indicated she had started employment two-three weeks prior and indicated she was unsure if that was a regulation or not. On August 31, 2022, at 3:00 p.m., licensed assisted living director (LALD)-A stated normally the receptionist would post the daily staffing plan	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 4 on the wall, but the receptionist had been out on a medical leave the past couple of weeks. No one had taken on the task in her absence. The licensee's Direct-Care Staffing: Plan, Scheduling and Posting policy undated, noted the daily work schedule would be posted in a central location, accessible to staff, 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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 5 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 included document titled, Food and Beverage Establishment Inspection Report dated August 31, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 6 staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records included all required content for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-D began providing direct care services for the licensee on August 1, 2021.	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 7 ULP-D's record lacked an annual performance review. On August 30, 2022, at 11:30 a.m., the surveyor observed ULP-D performing a blood sugar check and administering medications to R1. On August 31, 2022, at 2:05 p.m., human resources director (HRD)-G confirmed ULP-D's employee file did not include a current performance review. The licensee's Performance Review policy dated March 3, 2022, indicated the licensee will provide all associates the opportunity to have their performance evaluated annually based on the associate's current job responsibilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment,	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 8 including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, 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 August 30, 2022, at approximately 10:45 a.m. with Vice President of Housing Services (VPHS)-H and Director of Maintenance (DM)-C it was observed that the automatic door closer had been removed from trash room #232 on the second floor. The door closer is required to ensure that the door will automatically close and latch to maintain the fire barrier from the corridor. DM-C visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 9 (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of 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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements and failed to conduct required evacuation drills for fire safety and evacuation. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 10 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: A record review and interview were conducted on August 30, 2022, at approximately 11:30 a.m. with Vice President of Housing Services (VPHS)-H and Director of Maintenance (DM)-C on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the fire safety and evacuation plan did include procedures for resident movement, evacuation, or relocation during a fire or similar emergency but did not include the identification of unique or unusual resident needs for movement or evacuation. During interview, VPHS-H verified that the fire safety and evacuation plan lacked these provisions. Record review of the available documentation indicated that the licensee did not conduct evacuation drills every other month as required by statute. Provided documentation indicated that the last drill conducted for employees was dated 12/31/22 and drill documentation did not specify that evacuation was practiced. During interview, VPHS-H and DM-C stated that there were no further drills conducted and verified this deficient finding.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01060	Continued From page 12 if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R3 was admitted to assisted living services on December 9, 2020. R3's Service Plan with Schedule dated July 3, 2022, indicated R3 received the following services: medication administration, urinary catheter care to measure output and empty bag every shift, assistance with bathing, dressing, housekeeping, and laundry. R3's progress notes dated May 5, 2022, at 9:00 p.m., indicated the licensee sent R3 to the emergency room at a nearby hospital, due to	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01060	Continued From page 13 "resident actively having dark red/brown emesis and a lot of it. Also reported that there was red blood in his toilet, resident was pale and weak. Resident wanted to go to the Dr." R3 returned to the facility on June 7, 2022, after his stay at the hospital and short-term rehabilitation facility. R3's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R3's record lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On August 31, 2022, at 8:53 a.m., licensed assisted living director (LALD)-A stated she was not familiar with this requirement until a couple of months ago and had not had an emergency relocation since learning of the requirement. LALD-A verified nothing had been sent to the resident or the ombudsman. The licensee's Notice of Intent to Discharge policy	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01060	Continued From page 14 dated 2022, included the facility would follow all the applicable requirements of Minnesota Statutes Chapter 144G and Minnesota Administrative Rules Chapter 4659 that govern termination of a resident's assisted living contract and the discharge, transfer, emergency relocation, or other involuntary movement of a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01290	Continued From page 15 two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired on January 13, 2015, and started providing direct care and services to the licensee's residents under the assisted living license on August 1, 2021. On August 30, 2022, at 11:30 a.m., the surveyor observed ULP-D check R1's blood sugar and administer medications. ULP-D's employee record contained a background study dated January 14, 2015, for a separate location operated by the licensee's owner. ULP-D's employee record lacked evidence the licensee affiliated a background study for their license. On August 31, 2022, at 11:50 a.m., licensed assisted living director (LALD)-A confirmed ULP-D's background study had not been affiliated with the assisted living facility license. The licensee's Background Checks policy revised September 27, 2021, indicated: Transfers: When an individual transfers between Benedictine communities or between the Support Center and a community, or when an individual returns to the	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01290	Continued From page 16 Support Center or a Benedictine community following a break in service, a new background check will be completed unless the prior background check was completed in the preceding 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
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 delegated procedures were followed for one of three residents (R1) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01750	Continued From page 17 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's signed physician orders dated August 30, 2022, included an order for Novolog Flexpen U-100 insulin pen, 100 units per milliliter, inject 25 units subcutaneous (under the skin) three times a day. R1's Service Plan date September 9, 2022, indicated the resident needs assistance with storage, preparation, set-up, or blood sugar checks only and then resident is able to administer insulin on own or with cues or set up. On August 30, 2022, at 11:30 a.m., the surveyor observed unlicensed personnel (ULP)-D preparing R1's Novolog insulin pen for administration. ULP-D removed the cap, obtained an alcohol wipe, and swabbed the end of the insulin pen prior to applying the needle. Once the needle was applied to the pen, ULP-D then dialed the insulin pen to the prescribed dosage. ULP-D did not prime the insulin pen with two units to remove any air prior to dialing the dosage. When interviewed following R1's insulin administration, ULP-D confirmed she had not primed R1's insulin pen and should have. On August 31, 2022, at 8:37 a.m., registered nurse (RN)-F confirmed ULP's were trained to prime the insulin pens with two units prior to dialing up the dosage. ULP-D's Insulin Pen Competency dated April 15,	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01750	Continued From page 18 2022, included: Twist to remove cap on insulin pen needle, clean rubber stopper with alcohol swab and screw onto pen until needle cap meets resistance. Perform two unit air shot. Select the dose by turning the dose selector clockwise. Dial the number of units you need to inject. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
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 medications were labeled correctly for one of four residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 19 The findings include: R5's physician orders dated July 15, 2022, included an order for Polytrim (anti-bacterial eye drop) one (1) drop into left eye once every morning. R5's medication administration record (MAR) dated August 2022, included the same order for Polytrim 1 drop into the left eye once in the morning. On August 30, 2022, at 8:30 a.m., unlicensed personnel (ULP)-D obtained the Polytrim eye drop from R5's locked medication cupboard and washed her hands, applied gloves. The surveyor examined the eye drop label on the medication and noted the label did not match the order. The label had R5's name on it, but it read "1 drop to affected eyes every 4 hours". The eye drop further lacked a date open. ULP-D verified the label did not match the order and did not have a date open. On August 30, 2022, at 2:36 p.m., registered nurse (RN)-F stated all medications should have a label that matches the physician order. RN-F further stated all eye drops should have a date open/expiration sticker and all eye drops were disposed of after 28 days. The licensee's Medication Labeling policy revised January 2020, identified prescription medications must have a pharmacy label that accurately reflects the most current dose and directions for use. No further information provided. TIME PERIOD FOR CORRECTION: seven (7)	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 20 days	01890		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 21 review, the licensee failed to develop an individualized treatment management plan to include all required content for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: During the entrance conference on August 29, 2022, at 9:36 a.m., director of nursing (DON)-B stated the licensee provided treatment management services to the licensee's residents. R2 R2's medical record included diagnosis of diabetes mellitus. R2's Service Plan with Schedule dated, March 30, 2022, indicated R2 required assistance with blood sugar checks three times daily. R2's physician orders dated August 23, 2022, included an order to check blood sugars three times daily. On August 30, 2022, at 12:22 p.m., the surveyor observed unlicensed personnel (ULP)-D check R2's blood sugar. R2's blood sugar reading was 67, and ULP-D called the nurse. ULP-D stated R2 did not have specific parameters of when to	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 22 report to nurse but thought anything under 100 or over 300 should be reported. R2's treatment and therapy management plan dated March 30, 2022, indicated R2 received treatments to include blood sugar checks, but lacked procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment or therapy management services. In addition, R2's record lacked parameters for blood glucose results. R3 R3's diagnoses included chronic kidney disease, history of urinary tract infections, and urinary retention. R3's Service Plan with Schedule dated July 3, 2022, indicated R3 required assistance with urinary catheter to measure output and empty bag every shift. R3's physician orders dated August 28, 2022, included an order for catheter change every 3 weeks. On August 30, 2022, at 9:18 a.m., the surveyor observed ULP-D drain and measure R3's urinary catheter drainage bag. ULP-D then switched the overnight drainage bag to a leg bag. ULP-D stated there were no special instructions but thought cloudy or blood tinged urine should be reported to a nurse. R3's treatment and therapy management plan dated July 3, 2022, indicated R3 received treatments to include catheter cares and urine output measurement, but lacked procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30806	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE COURT	1906 NORTH SUNRISE DRIVE SAINT PETER, MN 56082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 23 arises with treatment or therapy management services. On August 31, 2022, at 10:13 a.m., DON-B confirmed there was no blood sugar parameters for the staff to follow and the treatment management plan lacked information on when to notify the RN for both R2 and R3. The licensee's Treatment and Rehabilitative Therapy Management dated 2021, noted the individual treatment management plan would include procedures for staff to notify the RN when a problem arose with treatment management services and documentation of specific resident instructions related to the treatments or therapy administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health
Food, Pool, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/30/22*
Time: 11:20:50
Report: 1020221107

Food and Beverage Establishment Inspection Report

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

Establishment Info:
ID #: 0038915
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5079348817
ID #:

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

The following orders were issued during this inspection.

4-300 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.

NO IRREVERSIBLE REGISTERING TEMPERATURE INDICATOR USED FOR THE HOT SANITIZING DISHWASHER; PROVIDE. EXAMPLES INCLUDE A WATERPROOF MIN/MAX THERMOMETER, THERMOLABELS, AND A DISH TEMP. CONTINUED IN THE GENERAL COMMENTS.

Comply By: 09/13/22

Surface and Equipment Sanitizers

Wash Temperature Gauge: = at 150 Degrees Fahrenheit
Location: DISHWASHER, AFTER SEVERAL PASSES
Violation Issued: No

Final Rinse Temperature Ga: = at 185 Degrees Fahrenheit
Location: DISHWASHER, AFTER SEVERAL PASSES
Violation Issued: No

Utensil Surface Temperatur: = at 160 Degrees Fahrenheit
Location: DISHWASHER, AFTER SEVERAL PASSES
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: <0 Degrees Fahrenheit - Location: FOODS FRIM - UPRIGHT FREEZER
Violation Issued: No

Type: Full
Date: *08/30/22*
Time: 11:20:50
Report: 1020221107
Benedictine Court

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: CUT MELON - UPRIGHT COOLER
Violation Issued: No

Process/Item: Hot Holding
Temperature: 178 Degrees Fahrenheit - Location: SHRIMP SCAMPI - STEAM TABLE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 149 Degrees Fahrenheit - Location: NOODLES - STEAM TABLE
Violation Issued: No

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

GENERAL COMMENTS:

4-302.13B CONTINUED - USE DAILY TO ENSURE THE UTENSIL SURFACE TEMPERATURE REACHES 160F MINIMUM. ADD A COLUMN TO EXISTING DISHWASHER TEMPERATURE LOG TO DOCUMENT UTENSIL SURFACE TEMPERATURE.

DISCUSSED EMPLOYEE ILLNESS POLICIES AND PROCEDURES. A FORM IS FILLED OUT FOR EACH EMPLOYEE ILLNESS AND HUMAN RESOURCES FOLLOW-UPS ON EMPLOYEE ILLNESS.

FOOD IS PREPARED IN THE NURSING HOME KITCHEN AND IS BROUGHT OVER USING INSULATED CARTS TO THE SERVING KITCHEN FOR SAME DAY SERVICE. HOT FOOD ITEMS ARE PLACED IN A STEAM TABLE AND COLD ITEMS ARE PLACED IN THE COOLER. TEMPERATURE OF ALL FOOD ITEMS ARE TAKEN UPON ARRIVAL TO THE SERVING KITCHEN AND DOCUMENTED ON A LOG. ANY LEFTOVERS ARE DISCARDED. LOGS ARE ALSO MAINTAINED FOR TEMPERATURE OF COLD-HOLDING UNITS.

SNACKS ARE PROVIDED THROUGHOUT THE DAY AND PLACED ON A CART FOR RESIDENTS.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1020221107 of 08/30/22.

Certified Food Protection Manager: Michelle J. Selbrade

Certification Number: FM21821 Expires: 02/26/23

Inspection report reviewed with person in charge and emailed.

Signed: Report emailed
Establishment Representative

Signed: Ashley B
Ashley B

651-201-4500

Report #: 1020221107

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pool, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out	0	Date	08/30/22
No. of Repeat RF/PHI Categories Out	0	Time In	11:20:50
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Benedictine Court	1906 North Sunrise Drive	St Peter, MN	56082	5079348817

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038915		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) Report emailed **Date:** 09/13/22

Inspector (Signature)