Electronically Delivered

December 4, 2024

Licensee
St. Benedict's Court
1301 East 7th Street
Monticello, MN 55362

RE: Project Number(s) SL20806016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 24, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

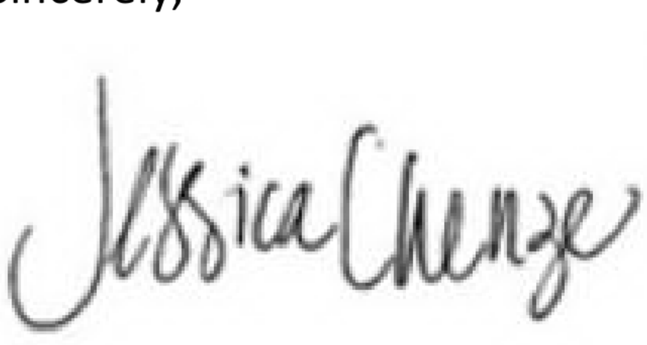
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax:1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20806	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICT COURT	1301 EAST 7TH STREET MONTICELLO, MN 55362

(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: SL20806016-0 On October 21, 2024, through October 24, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 87 residents; all receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (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 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 21, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance	0 550		

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0 550	Continued From page 2 procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required contact information for the individuals who were responsible for handling resident grievances. This had the potential to affect all current 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, 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 failed to post information including the e-mail contact information for the individuals who were responsible for handling resident	0 550		

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0 550	Continued From page 3 grievances. During the facility tour on October 21, 2024, at 1:45 p.m., the surveyor observed the bulletin board near the entrance of the facility with business representative (BR)-H and noted the posted grievance procedure. The licensee's Complaint Policy and Procedure, effective August 1, 2021, listed the names and titles of the individuals to contact with a grievance internally, with phone numbers; however, the document lacked the email contact information, as required. On October 24, 2024, at 12:44 p.m., licensed assisted living director (LALD)-B stated the contact information lacked the email address for the individuals listed to contact with a grievance internally, and it would be fixed immediately. The licensee's Complaint Policy and Procedure policy, effective August 1, 2021, indicated each resident or resident representative would receive written notice off the facility's process for receiving and resolving complaints that would include the name and contact information of the person representing the facility designated to handle and resolve complaints. The policy did not include the required content of the contact information of the person responsible for handling resident grievances, to include the email contact information, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		

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0 640	Continued From page 4	0 640		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting the 911 emergency number in common areas as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During the facility tour on October 21, 2024, at 1:45 p.m., with business representative (BR)-H, the surveyor observed the common areas in the	0 640		

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0 640	Continued From page 5 facility and two bulletin boards on the main floor with facility information, and did not observe the 911 emergency number posted. On October 23, 2024, at 1:18 p.m., licensed assisted living director (LALD)-B observed the common areas with the surveyor, and stated the receptionist's phone behind the reception area had a sticker with the 911 emergency number, and the phone in the clinical staff office had a sticker with the 911 emergency number; however, she did not see the 911 emergency number posted in the common areas. LALD-B stated she would be posting this immediately. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	0 660		

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0 660	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included documentation of a completed TB history and symptom screening for two of four employees (licensed practical nurse (LPN)-E, unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 with clinical nurse supervisor (CNS)-A on October 21, 2024, at 10:23 a.m., the surveyor requested to review the facility TB risk assessment. The TB risk assessment provided was dated June 13, 2024, and indicated the licensee was a "LOW" risk. LPN-E LPN-E had a start date of March 16, 2009. LPN-E's employee record contained evidence of a two-step tuberculin skin test, dated March 13, 2009, and March 23, 2009; however, the record lacked evidence of a completed TB history and	0 660		

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0 660	Continued From page 7 symptom screening as required. ULP-F ULP-F had a start date of April 2, 2024. ULP-F's employee record contained evidence of a blood test, dated April 11, 2024; however, the record lacked evidence of a completed TB history and symptom screening as required. On October 24, 2024, at 9:30 a.m., CNS-A stated LPN-E and ULP-F's records did not contain a TB history and symptom screening. CNS-A stated she didn't know where LPN-E's screening was and stated she assumed ULP-F's was completed at the provider that did her blood test. The licensee's TB Prevention and Control policy, effective August 1, 2021, indicated, at the time of hire and prior to any contact with residents, all assisted living employees and all volunteers who serve routinely would be screened for TB, which included a two-step TB test or blood test, and the RN would review the TB symptoms annually with all employees and volunteers. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be	0 660		

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0 660	Continued From page 8 documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance	0 940		

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0 940	Continued From page 9 through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for five of five residents (R1, R2, R3, R4, R5). 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 potential to affect a large portion or all of the residents). The findings include: R1, R2, R3, R4, and R5's Resident Agreement, signed by R1's legal representative on December 15, 2023, signed by R2's legal representative on September 23, 2024, signed by R3 on December 20, 2023, signed by R4's legal representative on December 19, 2023, and signed by R5's guardian on December 19, 2023, lacked the following required content: - whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided. On October 23, 2024, at 1:20 p.m., licensed	0 940		

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0 940	Continued From page 10 assisted living director (LALD)-A stated they were using the contracts being used prior to transitioning with the new owner, and stated she thought new contracts would soon be implemented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
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 and the Office of Ombudsman for Mental Health and Developmental Disabilities; (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	01060		

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01060	Continued From page 11 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 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.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, and designated representative, for one of one resident (R1) whom was hospitalized. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted and began receiving assisted living services on June 14, 2023.	01060		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01060	Continued From page 12 R1's Resident Notes - One Resident, dated February 15, 2024, indicated R1 was admitted to the hospital on February 15, 2024, through February 29, 2024, due to a fall with severe pain in the right middle upper thigh region and could not lift her leg independently. R1's record contained an AL (assisted living) Relocation Transfer Notice, and noted "date given" as February 20, 2024, and "date of relocation/transfer" as February 15, 2024. The notice indicated R1 was relocated to a local hospital due to a fall with weakness, and due to acute changes requiring transfer to hospital or emergency room. The notice also noted, R1's return date was unknown, the resident had a right to appeal this transfer/discharge to the State, and indicated, "If the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section [blank]." The notice included contact information for the State Long Term Care Ombudsman Office and the Office of Ombudsman for Mental Health and Developmental Disability. Finally, the notice included a line for a signature of the resident/resident representative with a box to check if "Unable to sign due to acute condition/911 transfer to Emergency Room," which was checked, and a line for a signature of the employee. At the bottom of the notice, were directions to provide copies to the resident/representative, case manager (If applicable). On October 22, 2024, at 1:30 p.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated they sent R1's duplicate relocation notice to the ombudsman on February 20, 2024, and they kept the original for the resident's record. CNS-A and LALD-B stated they	01060		

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	20806	A. BUILDING: _____ B. WING _____	10/24/2024

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ST BENEDICT COURT	1301 EAST 7TH STREET MONTICELLO, MN 55362

(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 do not give a copy of the relocation notice to the resident, legal representative and designated representative, as required, and have not given the relocation notice to the case manager, if applicable. In addition, CNS-A and LALD-B stated they did not realize the language for the right to appeal if the facility refused to provide housing or services after a relocation, was not complete. CNS-A and LALD-B stated the same form was used for all residents being relocated from the facility in an emergency. At 1:49 p.m., CNS-A and LALD-B stated they learned from the current managing company that a relocation notice was developed with the required content and was available to begin using immediately. R1's record lacked evidence of a written notice provided to the resident, the residents' legal representative, and designated representative that contained, at a minimum: - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=F	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	01290		

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01290	Continued From page 14 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 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 four 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 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: ULP-D began employment on February 13, 2024, to provide direct care for the licensee's residents. ULP-D's employee record contained a background study dated February 6, 2024, submitted through a separate location operated by the licensee's owner; however, ULP-D's employee record lacked evidence the licensee affiliated a background study for their assisted	01290		

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01290	Continued From page 15 living license. On October 21, 2024, at 3:27 p.m., human resources (HR)-C provided the NETStudy 2 roster as requested. ULP-D was not listed on the roster. On October 22, 2024, at 7:46 a.m., an email received from HR-C indicated ULP-D was not affiliated with this licensee. At 11:13 a.m., via email, HR-C indicated she could not explain why ULP-D's background study was not affiliated with the licensee. The licensee's Background Checks policy, effective August 1, 2021, indicated all employees must pass a background study and all contractors or volunteers with direct resident contact are required to have a background study. The policy lacked direction that the background study must be affiliated with the licensee, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days rig	01290		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include	01700		

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01700	Continued From page 16 an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized medication assessment with the required content for one of five residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on October 21, 2024, at 10:23 a.m., clinical nurse supervisor	01700		

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01700	Continued From page 17 (CNS)-A stated the licensee provided medication management services to the licensee's residents. On October 23, 2024, at 9:23 a.m., the surveyor observed R2 sitting on the couch in her apartment, wrapped in a blanket. R2 stated she received help from staff for showers and they brought her medications when it was time to take them. R2's diagnoses included mild cognitive impairment, depression, hearing loss, dyspnea (shortness of breath), weakness, and high blood pressure. R2's Addendum to Contract - Waiver - MN, identified as the service plan, and signed October 9, 2024, indicated R2 received medication administration three times per day. R2's Assessment by Date, dated September 25, 2024, identified as the admission assessment, indicated R2 needed help taking medications and needed full medication management and setup. The assessment indicated a current list of medications was reviewed including the reason taken, dosage, frequency of use, and route administered or taken. R2's Provider Orders, dated September 24, 2024, indicated R2's medications included a mild pain reliever, a supplement, an antihypertensive (treat high blood pressure), a stool softener, and a medication to decrease high cholesterol. R2's record lacked evidence the RN had conducted a medication assessment to include: - must be conducted face to face; - side effects; - contraindications; and	01700		

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01700	Continued From page 18 - allergic or adverse reactions, and actions to address these issues. On October 24, 2024, at 11:29 a.m., CNS-A stated the initial medication assessment in the licensee's software program required the nurse to click a button to include all of the required information and stated this did not happen on R2's assessments, therefore the medication assessment lacked the above required content. CNS-A stated if the required information was not completed during the initial assessment, the information would not pull through to subsequent assessments. The licensee's Initial and On-Going Nursing Assessment of Residents policy, effective August 1, 2021, indicated the registered nurse would complete a comprehensive assessment that would include medication review including over-the-counter medications, prescription medications and supplements including: - side effects, contraindications, allergic or adverse reactions; and - actions to address side effects, contraindications, allergic or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management	01730		

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01730	Continued From page 19 services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01730		

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01730	Continued From page 20 review, the licensee failed to develop an individualized medication management record with the required content for one of five residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on October 21, 2024, at 10:23 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. On October 23, 2024, at 9:23 a.m., the surveyor observed R2 sitting on the couch in her apartment, wrapped in a blanket. R2 stated she received help from staff for showers and they brought her medications when it was time to take them. R2's diagnoses included mild cognitive impairment, depression, hearing loss, dyspnea (shortness of breath), weakness, and high blood pressure. R2's Addendum to Contract - Waiver - MN, identified as the service plan, and signed October 9, 2024, indicated R2 received medication administration three times per day. R2's Provider Orders, dated September 24, 2024,	01730		

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01730	Continued From page 21 indicated R2's medications included a mild pain reliever, a supplement, an antihypertensive (treat high blood pressure), a stool softener, and a medication to decrease high cholesterol. R2's Individualized Medication Management Plan (IMMP), dated October 9, 2024, indicated R2 was unable to safely self-administer medications so staff provided medications as indicated by R2's primary care provider. The IMMP included a description of storage of R2's medications with interventions to prevent the diversion of medications by the resident or others who may have access to the medications, instructions provided to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications, medication management tasks that may be delegated to unlicensed personnel, method for unlicensed personnel to contact the nurse if questions or concerns arise, and indicated staff would administer medications per the electronic medication administration record (EMAR). R2's record lacked a medication management plan to include the following required content: - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. On October 24, 2024, at 11:29 a.m., CNS-A stated R2's record lacked a medication management plan with the above required content. The licensee's Individualized Medication, Treatment, and Therapy Management Plans policy, effective August 1, 2021, indicated the registered nurse would develop a medication	01730		

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01730	Continued From page 22 management plan for each resident receiving medication management services that would include identification of persons responsible for monitoring and ensuring timely refills of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were secure and permitted only authorized personnel access, for one of two medication storage areas (Memory Care North). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01880		

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01880	Continued From page 23 The licensee held an assisted living with dementia care license and was licensed for capacity of 98 residents, including residents receiving assisted living services and residents residing in two separate memory care units (dementia care units - North and South). Resident medications were stored in each resident's room, in a locked cabinet; however, controlled medications were double locked in the locked nursing offices located in the Memory Care South unit, and the Memory Care North unit. On October 23, 2024, at 12:55 p.m., during observation of medication storage with clinical nurse supervisor (CNS)-A, the surveyor observed six large cardboard boxes containing several punch packs of medications, stacked in the locked Memory Care North nursing office, in the open area. Medication punch packs were also observed lying on a desk, in the open area. When asked about the medications, CNS-A stated some of the medications were "extra," some punch packs were "empty," and some of the medication punch packs had been delivered by the pharmacy and needed to be put into the locked cabinets in the residents' rooms. At 1:07 p.m., life enrichment (LE)-I entered the nursing office after opening the door with the keypad, and used the printer in the open area. On October 23, 2024, at 1:15 p.m., CNS-A stated various staff in the facility needed access to the nursing office to use the facility printer, therefore, they had access with the keypad. CNS-A stated usually nursing staff were in the office to monitor the medications, however, stated there were times when the nurses needed to leave the office to provide services to residents and the office was left unattended. CNS-A stated they would need to consider a different process to ensure	01880		

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01880	Continued From page 24 medications were secured. The licensee's Storage of Medications policy, effective August 1, 2021, indicated the registered nurse would establish a system that addressed the storage and handling of medications, including how medications would be received and secured when delivered by the pharmacy, where medications would be stored, how the medications would be secured if in the client's private living space or if centrally stored, and who was authorized to access medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

Minnesota Department of Health
Environmental Health Division
3333 W. Division #212
St. Cloud
320-223-7300

Type: Full
Date: *10/21/24*
Time: 11:15:15
Report: 1041241244

Food and Beverage Establishment Inspection Report

Location:

St Benedicts Sen Com The Court
1301 East 7th Street
Monticello, MN55362
Wright County, 86

Establishment Info:

ID #: 0037761
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632954051
ID #:

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

The following orders were issued during this inspection.

4-600 Cleaning Equipment and Utensils

4-601.11C

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

CLEAN THE GASKET ON THE 2-DOOR UPRIGHT COOLER IN THE VILLAGE KITCHEN TO REMOVE DIRT AND MOLD.

Comply By: 10/28/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

PROVIDE A HAND WASHING SIGN AT THE HAND SINK IN THE VILLAGE KITCHEN.

Comply By: 11/04/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Hot Water: = at 169 Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE CYCLE
Violation Issued: No

Hot Water: = at 179 Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE CYCLE -THE VILLAGE
Violation Issued: No

Type: Full
Date: *10/21/24*
Time: 11:15:15
Report: 1041241244
St Benedicts Sen Com The Court

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Walk-In Cooler
Temperature: 41 Degrees Fahrenheit - Location: CHEESECAKE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 157 Degrees Fahrenheit - Location: MASHED POTATOES IN WARMING OVEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MILK IN 4-DOOR UNIT
Violation Issued: No

Process/Item: Hot Holding
Temperature: 171 Degrees Fahrenheit - Location: SALISBURY STEAK
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MILK IN 2-DOOR UNIT-THE VILLAGE
Violation Issued: No

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

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 1041241244 of 10/21/24.

Certified Food Protection Manager: HEIDI BOON

Certification Number: 63595 Expires: 06/05/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Linda Heinen
Linda Heinen
Public Health Sanitarian
St. Cloud
320-223-7306
Linda.Heinen@state.mn.us

Report #: 1041241244

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Environmental Health Division
3333 W. Division #212
St. Cloud

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 10/21/24
Time In 11:15:15
Time Out

	Address	City/State	Zip Code	Telephone
St Benedicts Sen Com The Court	1301 East 7th Street	Monticello, MN	55362	7632954051

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037761		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		Warewashing facilities: installed, maintained, & used; test strips		
49	X	Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 10/21/24

Inspector (Signature) Linda Hinen