DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

March 29, 2023

Licensee
Benedictine Living Community
1705 Windermere Way
Shakopee, MN 55379

RE: Project Number(s) SL36413015

Dear Licensee:

On March 14, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 14, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3789 Fax: 651-281-9796

JMD

Electronically Delivered

January 9, 2023

Licensee
Benedictine Living Community
1705 Windermere Way
Shakopee, MN 55379

RE: Project Number(s) SL36413015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 14, 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.

LICENSING ORDERS
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, the following fines are assessed pursuant to this evaluation:

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

St - 0 - 1880 - 144g.71 Subd. 19 - Storage Of Medications - $3,000.00

The total amount you are assessed is $3,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-201-3789 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36413	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	1705 WINDERMERE WAY SHAKOPEE, MN 55379

(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: SL36413015 On December 12, through December 14, 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 196 active residents; 68 receiving services under the Assisted Living with Dementia Care license. On December 13, an immediate order was issued for 1880. The immediacy was removed on December 14, 2022.	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 with Dementia Care. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	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: (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 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 December 12, 2022, for the specific	0 480		

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0 480	Continued From page 2 Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, 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 all staff, residents and visitors.)	0 510		

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0 510	Continued From page 3 The findings include: On December 13, 2022, at approximately 7:15 a.m., unlicensed personnel (ULP)-B entered R5's room to provide medication administration and perform a blood glucose test to R5. ULP-B failed to perform hand hygiene prior to entering R5's room, prior to donning (putting on), and doffing (taking off) gloves after performing blood glucose testing on R5. On December 13, 2022, at approximately 7:40 a.m., ULP-B completed cares with R5 and proceeded to R3 and R4's room. ULP-B failed to perform hand hygiene after exiting R5's room, prior to entering R3 and R4's room, and after exiting R3 and R4's room. On December 13, 2022, at approximately 1:00 p.m., licensed assisted living director (LALD)-D and director of nursing (DON)-A stated all staff should be performing hand hygiene prior to entering resident rooms, after exiting resident rooms, and with donning and doffing gloves. The licensee's Standard (Universal Precautions) for Infection Control policy with copyright of 2022, indicated staff would perform hand hygiene between all patient contact and before and after use of gloves. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 4 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include statements of the specific measures to be taken to minimize the risk of abuse for two of five residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: On December 12, at approximately 1:00 p.m., regional registered nurse (RN)-E indicated assessments, IAPPs, and service plans for all residents were included in a single document	0 630		

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0 630	Continued From page 5 titled Service Plan with Schedule. R3 and R4 were both admitted on June 17, 2022. R3's Service Plan with Schedule signed October 31, 2022, section IAPP Vulnerable Adult and Individual Abuse Prevention Plan failed to indicate if R3 was susceptible to abuse or risk to abuse others. Additionally, the IAPP failed to include statements of the specific measurements the licensee would take to minimize R3's risks. R4's Service Plan with Schedule signed October 3, 2022, section IAPP Vulnerable Adult and Individual Abuse Prevention Plan failed to indicate if R4 was susceptible to abuse or risk to abuse others. Additionally, the IAPP failed to include statements of the specific measurements the licensee would take to minimize R4's risks. On December 13, 2022, at approximately 1:00 p.m., licensed assisted living director (LALD)-D and director of nursing (DON)-A indicated the licensee was already aware the contents of the IAPPs for the residents was lacking and a new process was already implemented prior to the survey initiation. LALD-D stated R3 and R4's respective IAPPs had not had the new process and documentation completed for them lacked the required intervention to minimize risks. The licensee's Individualized Abuse Plan policy with copyright of 2021, indicated all residents would have an IAPP with specific interventions to minimize risks completed and implemented. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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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 in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 14, 2022, between 11:00 a.m. and 3:30 p.m., survey staff toured the facility with Licensed Assisted Living Director (LALD)-D, and Environment Service Director (ESD)-G, and Plant operation Supervisor (POS)-H. During the facility tour, survey staff observed the following: The left side trash chute door on the fourth floor adjacent to room 4008 did not self-latch. The	0 800		

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0 800	Continued From page 7 trash chute door should close and latch completely to maintain the fire resistance integrity of the trash chute system. The two maintenance access doors above the trash intake doors on the fourth floor adjacent to room 4008 were left open and filled with garbage. The trash maintenance access doors should closed and locked to maintain the fire resistance integrity of the trash chute system. (POS)-H stated that the chute maintenance door should remain locked all the time. The left side trash chute door on the fourth floor adjacent to room 4020 did not self-latch. The fourth-floor laundry room had considerable damage to the sheetrock ceiling with evidence of water damage. During the interview, (POS)-H stated that he suspected that there could be issues with the exhaust pipe above the ceiling and condensation coming from missing flashing or possibly penetration through roofing underlayment. The south wing cross-corridor fire-rated doors on the third floor that separating the assisted living building from the public area were propped open with a door wedge. The rubber wedge would prevent the doors from closing properly in the event of a fire. In resident room 1103, the bathroom light over the vanity did not work. In the laundry room on the third floor, the door did not close due to hardware did not latch correctly. During the facility tour interview, LALD-D, ESD-G and POS-H visually verified these deficient findings at the time of discovery.	0 800		

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

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0 810	Continued From page 9 This MN Requirement is not met as evidenced by: Based on record review, interview, and observation the licensee failed to provide a maintained fire safety and evacuation plan that contains employee actions to be taken in the event of a fire or similar emergency, fire protection procedures necessary for residents, and procedures necessary for resident movement, evacuation, or relocation during fire or similar emergency with identification of unique or unusual resident needs for the movement or evacuation. The licensee also failed to conduct evacuation drills for employees at least twice per year per shift with at least one evacuation drill every other month. These deficient practices had the ability 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). The findings include: An interview and record review were conducted on December 14, 2022, between approximately 11:30 a.m. and 3:30 p.m. with the Licensed Assisted Living Director (LALD)-D, and Environment Service Director (ESD)-G, and Plant operation Supervisor (POS)-H. on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility.	0 810		

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0 810	Continued From page 10 Record review of the available documentation indicated that the fire safety and evacuation plan did not include the facility-specific 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. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. The policy was a basic policy from a third-party provider and had not been edited or updated to fit the facility. During the interview, (LALD)-D verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. During the interview, (LALD)-D stated that the facility did not have documentation or a policy on offering annual resident training on the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted on 9-1-22 and 10-1-22 with no further drills being documented. (LALD)-D verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36413	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	1705 WINDERMERE WAY SHAKOPEE, MN 55379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 11	01880		
01880 SS=G	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 stored securely for one of one resident (R3) with medication management services, and failed to monitor a medication refrigerator according to the manufacturer's directions. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: STORAGE R3 was admitted on June 17, 2022, with diagnoses including Alzheimer's disease, anemia, hypertension, and hypothyroidism. R3's Service Plan with Schedule signed October 31, 2022, read under Medication Reminders and Administration, "Requires staff to administer pills or liquids, staff assist with storage and preparation."	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36413	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	1705 WINDERMERE WAY SHAKOPEE, MN 55379

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01880	Continued From page 12 R3's Medication Management Assessment 3.2 with effective date of November 1, 2022, read, "23 Medications at risk for diversion - Has no medications at risk for diversion/meds are locked up and nurse does medication check weekly." On December 13, 2022, at approximately 7:15 a.m., the surveyor observed R3's room and noted unsecured medications stored on the island of R3's kitchen. Medications keep unsecured on the island included doxycycline (antibiotic), melatonin (sleep aid), loperamide (anti-diarrheal), AREDS 2 (vitamin for eyesight), cold & cough (generic brand from pharmacy), bromfenac (eye drop), refresh tears (eye drop), diclofenac sodium 1% (topical anti-inflammatory gel), and Tylenol tablets (pain relief). At that time, R3 walked out of R3's bedroom and stated, "do you know where I am?" Additionally, R3 stated, "I am not sure what is going on, but that is what happens sometimes." On December 13, 2022, at approximately 8:00 a.m., unlicensed personnel (ULP)-B indicated the licensee provided medication management to R3, but not to R3's roommate/husband, R4. ULP-B stated mediations on the island were owned and labeled for R4, who was assessed as independent with medications. ULP-B indicated R3's medications were all locked in a cabinet as R3 was not to have access to the medications due to R3's diagnoses and possibility of misusing medications. On December 13, 2022, at approximately 1:00 p.m., licensed assisted living director (LALD)-D and director of nursing (DON)-A indicated R3 should not have access to medications based on the assessment completed by DON-A.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36413	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY	1705 WINDERMERE WAY SHAKOPEE, MN 55379

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01880	Continued From page 13 The licensee's Storage of Medications policy with copyright date 2021, indicated the licensee would store medications based on the registered nurse's assessment which included if medications could be diverted or the "client's cognitive status." REFRIGERATOR On December 12, 2022 at 12:30 p.m.. the surveyor observed a medication refrigerator located in the locked medication room on the secured dementia unit with registered nurse (RN)-F. The refrigerator was observed to have resident medications including four unopened Lantus insulin pens (a multiple dose pen shaped injector device for insulin administration) stored in the refrigerator. Fridge Temperature Log, from October 01, 2022, through December 12, 2022, indicated the refrigerator temperature was not recorded for thirty two days of three months; and the temperature was out of range at 50 degrees F twenty two days of three months. On December 12, 2022 at 12:30 p.m. RN-F verified that the medication refrigerator log was not recorded for thirty-two days, and the temperature was out of range at 50 degrees F twenty-two days of three months. RN-F explained that morning staff logs the temperatures daily and temperatures were expected to be maintained between 35-46 degrees Fahrenheit The manufacturer's instructions for undated Lantus insulin pens, indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Lantus to freeze. The licensee's Storage of Medications policy with	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36413	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01880	Continued From page 14 copyright dated 2022, indicated, "the proper storage of medication including the need to be refrigerated, or stored in cool, dry area, and according to manufacturer's". No further information provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by review by evaluation supervisor on December 14, 2022, however noncompliance remains at a scope and severity of G. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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

Type: Full
Date: *12/12/22*
Time: 11:00:00
Report: 8041221364

Food and Beverage Establishment Inspection Report

Location:
Benedictine Living Community
1705 Windermere Way
Shakopee, MN55379
Scott County, 70

Establishment Info:
ID #: 0039246
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9529005200
ID #:

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

The following orders were issued during this inspection.

3-100 Food Characteristics: unadulterated

3-101.11 ** Priority 1 **

MN Rule 4626.0125 Remove all unsafe and adulterated foods from the premises.

CONTAINER OF WHIPPED BUTTER THAT CONTAINED MOLD FOUND IN THE UPRIGHT NORLAKE COOLER. DISCARDED DURING INSPECTION.

Comply By: 12/12/22

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

MILK HELD ON ICE ON CART DURING SERVICE AT 47 DEG F. MILK MUST BE STORED USING MECHANICAL REFRIGERATION UNLESS AN TIME AS A PUBLIC HEALTH CONTROL POLICY IS APPROVED BY MDH. MILK WILL BE DISCARDED IF NOT USED DURING SERVICE TODAY.

Comply By: 12/12/22

3-800 Highly Susceptible Populations

3-801.11B ** Priority 1 **

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

UNPASTEURIZED EGGS ARE BEING USED TO MAKE OVER-EASY EGGS DURING BREAKFAST SERVICE. HIGHLY SUSCEPTIBLE POPULATION RESTRICTIONS FOR EGGS REVIEWED WITH THE PIC. ESTABLISHMENT IS PLANNING TO PURCHASE PASTEURIZED EGGS.

Comply By: 12/12/22

4-700 Sanitizing Equipment and Utensils

4-703.11B ** Priority 1 **

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

THE UTENSIL SURFACE TEMPERATURE FOR THE DISH MACHINE IN THE MAIN KITCHEN MEASURED 136 DEG F. USE THE THREE COMPARTMENT SINK FOR DISHWASHING UNTIL MACHINE IS WORKING PROPERLY.

Comply By: 12/12/22

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO QUATERNARY AMMONIUM TEST KIT ON SITE TO MEASURE THE SANITIZER CONCENTRATION.

Comply By: 12/19/22

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ** Priority 2 **

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

HAND SINK IN THE FRONT SERVICE AREA AND IN THE MEMORY CARE KITCHEN WERE BLOCKED BY EQUIPMENT AT TIME OF INSPECTION. CORRECTED ON SITE.

Comply By: 12/12/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

ESTABLISHMENT DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER. APPLICATION SENT TO ESTABLISHMENT.

Comply By: 12/12/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: 3 compartment sink dispenser
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: sani bucket- cookline
Violation Issued: No

Utensil Surface Temp.: = at 136 Degrees Fahrenheit
Location: dish machine- main kitchen
Violation Issued: Yes

Utensil Surface Temp.: = at 165 Degrees Fahrenheit
Location: dish machine- cafe
Violation Issued: No

Utensil Surface Temp.: = at 163 Degrees Fahrenheit
Location: dish machine: memory care
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: walk-in cooler: hard boiled egg
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: walk-in cooler: sliced cheese
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: walk-in cooler: split pea soup
Violation Issued: No

Process/Item: Hot Holding
Temperature: 200 Degrees Fahrenheit - Location: steam table: chicken noodle soup
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: grill drawer: sausage patty
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: line cooler: cut melon
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: line cooler: turkey
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: line cooler: shredded cheese
Violation Issued: No

Process/Item: Cold Holding
Temperature: 47 Degrees Fahrenheit - Location: cart on ice: milk
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: upright cooler- memory care: yogurt
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: norlake upright cooler: whipped cream
Violation Issued: No

Type: Full
Date: *12/12/22*
Time: 11:00:00
Report: 8041221364
Benedictine Living Community

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	4	2	1

Inspection was completed with Joe Schultz (Culinary Services Director). Lead Health Regulation Division Nurse Evaluator, Brandon Mueller was also on site completing site survey.

Establishment has a commercial kitchen on the second floor, a serving kitchen in memory care, a cafe on the main level and additional food storage in the basement. The cafe is currently only being used for coffee and pastries.

Discussed the following:
Employee illness policy and logging requirements
Reportable diseases
Glove-use and bare hand contact
Vomit clean up procedures
Highly susceptible population restrictions
Thermometer calibration and temperature logs
Self inspections
Violations on this report

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 8041221364 of 12/12/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Joe Schultz
Culinary Services Director

Signed: Sarah Conboy
Sarah Conboy
Public Health Sanitarian III
651-201-3984
sarah.conboy@state.mn.us