Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 28, 2023

Licensee
Benedict House
3883 19th Avenue Northwest
Rochester, MN 55901

RE: Project Number(s) SL32176015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 2, 2023, 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 . . ."

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

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

Please address your cover letter for reconsideration requests to:

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in 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
State Evaluation Team
Health Regulation Division
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: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32176	A. BUILDING: ______ B. WING ______	03/02/2023

NAME OF PROVIDER OR SUPPLIER: **BENEDICT HOUSE**

STREET ADDRESS, CITY, STATE, ZIP CODE: **3883 19TH AVE NW, ROCHESTER, MN 55901**

(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: SL32176015-0 On February 27, 2023, through March 2, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 16 active residents; all of whom were receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the 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	0 470		

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Continued From page 2

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 with dementia care license. The facility was licensed for a capacity of 18, and had a current census of 16 residents receiving services.

On February 27, 2023, at 12:05 p.m. during a facility tour, the surveyor observed a document labeled "Staffing Hours report for Nursing at Madonna Towers AL" dated February 27, 2023, as posted in the entryway of the licensee's building. The document indicated for 6:00 a.m.-2:30 p.m., six certified nursing assistants (CNA)/resident assistants (RA), for registered nurse (RN)/director of nursing (DON) 8:00 a.m.-4:30 p.m. for a shift total of seven. Then for 2:00 p.m.-10:30 p.m. the schedule indicated six CNA/RA for a shift total of six staff. And for 10:00 p.m.-6:30 a.m. four CNA/RA.

On February 27, 2023, at 2:45 p.m. licensed assisted living director (LALD)-A and regional manager of housing/registered nurse (RMH-RN)-C stated the schedule posted in that building encompassed all the staff for each shift for both buildings on the campus. The scheduling tool used did not allow the option to differentiate the staff for each licensed building. RMH/RN-C stated, "I see the problem, we need to specify the schedule to the licensed building." LALD-A stated she would need to hand edit the schedule prior to posting in the building each day and would do so.

The Staff Schedule dated February 27, 2023,

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0 470	Continued From page 3 indicated the unlicensed personnel (ULP) and RN scheduled, but lacked the specific number of staff working in the licensee's dementia care unit, which held a separate license. The licensee's Direct-care staffing: Plan, Scheduling and Posting policy dated August 2021, indicated the 24-hour daily staffing schedule will include: Direct-care staff work schedules for each direct-care staff member, indication of all work shifts, including days and hours worked; identify direct-care staff member's resident assignments or work location; the daily work schedule will be posted at the beginning of each shift; the posted daily work schedule will not include direct-care staff members' residents' assignments; and the daily work schedule will be posted in a central location in each building of a facility or campus 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: (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		

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0 480	Continued From page 4 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 February 28, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	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.	0 510		

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0 510	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by one of three unlicensed personnel (ULP-E) 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) 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: The licensee failed to ensure removal of gloves and proper handwashing occurred between the steps of setting up and administration of medications. On February 27, 2023, at 2:00 p.m. ULP-E stated she was ready to set up and give medications to R4. ULP-E started the process by putting on gloves, unlocked R4's medication cabinet door, pulled out R4's medication bucket, pulled out the phone from her pocket and reviewed medications from the electronic medication record (eMAR). ULP-E set up two tablets of acetaminophen into a medication cup, continued with the same gloves, closed and locked the medication cabinet door, went to the kitchen cupboard and obtained a glass, went to the sink, turned on the faucet, filled the glass with water, and went to the dining table	0 510		

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where R4 waited. ULP-E assisted R4 with administration of the medication and with drinking from the glass. ULP-E then went to her phone to document the medications given, removed her gloves and washed her hands.

On March 2, 2023, at 11:05 a.m. registered nurse (RN)-B stated her expectation was for staff to remove gloves, complete proper hand hygiene, reapply gloves if necessary, remove them when completing the task and complete hand hygiene again.

The licensee's Hand Hygiene policy dated March 3, 2023, indicated handwashing shall be performed between client cares and whenever direct physical contact with a client takes place. Use of gloves does not replace handwashing. Hands should be washed or decontaminated before and after direct contact with a client and after contact with environmental surfaces or equipment in the immediate vicinity of the client.

No other information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

0 640 SS=F — 144G.42 Subd. 7 Posting information for reporting suspected c — 0 640

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

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0 640	Continued From page 7	0 640		

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 information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC). 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 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:

The licensee failed to post information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557.

During the facility tour on February 27, 2023, at 12:05 p.m. the evaluator observed the entry and common areas within the facility with licensed assisted living director (LALD)-A, and noted there was no posting of the information and reporting number for MAARC, as required.

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0 640	Continued From page 8 On February 27, 2023, at 2:45 p.m. LALD-A stated she thought the information was posted as required. She stated she had it clearly posted in the main building (separate license) but had not realized it was not posted in the memory care building. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the	0 730		

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resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;
(10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;
(11) documentation that services have been provided as identified in the service plan;
(12) documentation that the resident has received and reviewed the assisted living bill of rights;
(13) documentation of complaints received and any resolution;
(14) a discharge summary, including service termination notice and related documentation, when applicable; and
(15) other documentation required under this chapter and relevant to the resident's services or status.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged 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, 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:

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R3's record lacked a discharge summary to include:
- diagnoses;
- course of illness;
- allergies;
- treatments and therapies;
- pertinent lab, radiology, and consultation results; and
- a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status.

R3 began receiving services on January 22, 2014, and was discharged on December 6, 2022.

R3's discharge summary included the reason for initiation of services as assistance with ADLs (activities of daily living), meals, and housekeeping, client's condition upon discharge: stable, and status of medications upon discharge: Medications transferred to skilled nursing facility.

On March 1, 2023, at 2:40 p.m. registered nurse (RN)-B stated R3 first went to the hospital and was then transferred to a long-term care facility. RN-B completed the discharge summary form the licensee currently used, and indicated she was not aware of the required content of the discharge summary.

The licensee's Discharge Summary policy dated March 2, 2022, indicated the discharge summary would include:
a. Summary of the resident's stay, including
i. Diagnosis
ii. Courses of illnesses
iii. Allergies
iv. Treatments

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v. Therapies
vi. Pertinent lab results
vii. Pertinent radiology results
viii. Pertinent consultation results
ix. Final summary of the resident's status. The summary will be based upon the latest assessment or review and, if applicable, will include resident status including baseline and current mental, behavioral and functional status

No further information was provided.

TIME PERIOD FOR CORRECTIONS:
Twenty-one (21) days

0 910 SS=C — 144G.50 Subd. 2 (a-b) Contract information — 0 910

(a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility.
(b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:
(1) the facility and contracted service provider when applicable;
(2) the licensee of the facility;
(3) the managing agent of the facility, if applicable; and
(4) the authorized agent for the facility.

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 two of two residents (R1, R2). This had the potential to affect all 16 residents living in the assisted living with dementia care facility.

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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
0 910	Continued From page 12	0 910		

Continued From page 12

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
On February 28, 2023, at 7:45 a.m. unlicensed personnel (ULP)-F was observed to provide stand by assistance with R1 as he ambulated with his walker to his room. ULP-F administered 10 oral medications and one eye drop.

R1's unsigned Service Plan dated January 13, 2023, indicated he received services to include medication set up and administration, assistance with dressing, bathing, grooming and toileting, stand by assistance to ambulate, assistance with eyeglasses and hearing aids, and housekeeping.

R1's Assisted living Residency Agreement dated October 31, 2022, indicated the health facility identification number "24406," which was not the correct license number for the facility.

R2
On February 28, 2023, at 8:40 a.m. ULP-F was observed to assist R2 with a pulse check, blood pressure check, oral and eye medication administration, urinary catheter bag management, dressing and assistance with meal set up for breakfast.

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	32176	A. BUILDING: ___ B. WING ___	03/02/2023

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0 910	Continued From page 13 R2's unsigned Service Plan dated January 13, 2023, indicated he received services to include medication administration, daily heart rate and blood pressure, behavior redirection, assistance with dressing, grooming, bathing, toileting, emptying urinary catheter bag throughout the day, assistance with meal set up and observation during meals, and housekeeping. R2's Assisted Living Residency Agreement dated August 3, 2021, indicated the license number "20211" of the facility, which was not the correct license number for the facility. On March 2, 2023, at 11:20 a.m. licensed assisted living director (LALD)-A verified the wrong license number was indicated on the above resident contracts and stated there were several HFID (health facility identification) numbers within the larger campus, and was uncertain why these two residents had the HFID numbers as indicated. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
01060 SS=D	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;	01060		

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01060	Continued From page 14 (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 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 required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for	01060		

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01060	Continued From page 15	01060		

one of one resident (R1).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1 began receiving services on October 31, 2022, under the licensee's assisted living with dementia care license.

R1's unsigned Service Plan dated January 13, 2023, indicated he received services to include medication set up and administration, assistance with dressing, bathing, grooming and toileting, stand by assistance to ambulate, assistance with eyeglasses and hearing aids, and housekeeping.

Review of R1's nurse progress notes dated December 13, 2022, through December 21, 2022, indicated R1 was sent to the hospital for further evaluation for continued intermittent flank pain following a fall noted on December 9, 2022.

R1's hospital discharge summary dated December 21, 2022, indicated a hospitalization from December 13, 2022, to December 21, 2022, for care as the result of right and left sided rib fractures and a T-11 (thoracic level) of the anterior half of the vertebral body (front area of a spinal bone) fracture. R1 was discharged from the hospital and returned to the licensee's facility.

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01060	Continued From page 16 R1'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; and - 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. On March 2, 2023, at 10:00 a.m. registered nurse (RN)-B stated she was unable to find the relocation form for R1's hospitalization/relocation. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of	01470		

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01470	Continued From page 17 emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations,	01470		

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01470	Continued From page 18	01470		

isolation, and depression; or
(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-E) received orientation to assisted living facility licensing requirements and regulations before providing services.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

ULP-E was hired on February 7, 2022, as a "pool" staff under the licensee's assisted living with dementia care license.

On February 27, 2023, at 2:00 p.m. ULP-E was observed administering medications to R4.

ULP-E's record lacked evidence of receiving orientation to assisted living with dementia care to include the following required content:
- an overview of Assisted Living statutes;

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01470	Continued From page 19 - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and - principles of person-centered planning/service delivery On March 2, 2023, at 9:40 a.m. licensed assisted living director (LALD)-A stated the licensee did not have documentation of the above indicated training requirements and could not prove they were completed. The licensee's undated, Additional Orientation for AL (assisted living) Nursing Associates policy read "Associate providing and supervising nursing services complete an orientation to Assisted Living licensing requirements and regulations before providing services to residents. Associate are trained and competent in the provision of nursing care and assisted living services consistent with current practice standards and in accordance with the resident centered Service Pan [sic]. The Nursing orientation includes but is not limited to: - an introduction and review of policies and procedures related to the provision of assisted living services. -a review of the types of Assisted living services the employee will be providing and the provider's scope of assisted living license. -associate providing assisted living services are oriented specifically to each resident, their service plan." No further information was provided.	01470		

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01470	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised and signed by the resident or resident representative to reflect the current services provided for two of two residents (R1, R2).	01640		

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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:

R1
On February 28, 2023, at 7:45 a.m. unlicensed personnel (ULP)-F was observed to provide stand-by assistance with R1 as he ambulated with his walker to his room. ULP-F administered 10 oral medications and one eye drop. ULP-F stated R1 has needed some stand-by assistance with ambulation, and was supposed to be using his walker; R1 had grown a bit stronger with the assistance of physical therapy.

R1's unsigned Service Plan dated January 13, 2023, indicated he received services to include medication set up and administration, assistance with dressing, bathing, grooming and toileting, stand-by assistance to ambulate, assistance with eyeglasses and hearing aids, and housekeeping. R1's Service Plan lacked the service of physical therapy.

R1's Clinical Note dated December 15, 2022, at 8:47 a.m. indicated "therapy orders received on December 6, 2022, insurance verification form submitted to business office. As of December 14, 2022, no insurance information had been received by the therapy department, so therapy was unable to evaluate the resident prior to

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hospitalization. R1's record lacked documentation of when physical therapy started." No further notes regarding physical therapy were noted.

On March 1, 2023, at 3:00 p.m. registered nurse (RN)-B stated R1 started physical therapy on January 18, 2023, and R1's Service Plan was not updated to include this service. Additionally, RN-B stated she was not aware the Service Plans needed to be signed with changes or amendments to the residents' Service Plans. Regional director of Housing/registered nurse (RDH-RN)-C clarified for RN-B the corporate policy was for all Service Plan updates to be provided to residents/resident representatives and signed by them and the licensee.

On March 2, 2023, at 11:00 a.m. RN-B provided the surveyor with an updated/amended Service Plan dated March 2, 2023, which indicated under section labeled Stability/Falls: Services/Assistance Provisions read Report increasing evidence of unsteadiness or other safety concerns, resident is receiving physical therapy that was started on January 18, 2023. RN-B stated she was contacting R1's wife regarding the changes and would have her sign the Service Plan.

R2

On February 28, 2023, at 8:40 a.m. ULP-F was observed to assist R2 with a pulse check, blood pressure check, oral and eye medication administration, urinary catheter bag management, dressing and assistance with meal set up for breakfast. ULP-F stated R2 received physical therapy and a home care agency provided R2's indwelling urinary catheter management (changing catheter and providing supplies).

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R2's unsigned Service Plan dated January 13, 2023, indicated he received services to include medication administration, daily heart rate and blood pressure, behavior redirection, assistance with dressing, grooming, bathing, toileting, emptying urinary catheter bag throughout the day, assistance with meal set up and observation during meals, and housekeeping. R2's Service Plan was not updated to include the service of a home care agency's management of R2's catheter and supplies.

R2's record included only one signed Service plan and was dated August 5, 2021. Service Plan fees are based on a point system for services provided to the residents. Service Plan updates occurred on October 4, 2022, (103 points), November 23, 2022, (133 points), and January 13, 2023, (133 points), and none were signed by the resident/resident representative, nor the licensee.

On March 1, 2023, at 3:10 p.m. RN-B stated the home care agency's management of the urinary catheter change/supplies would need to be added to R2's Service Plan. RN-B stated she would need to check regarding the status of R2's physical therapy services but the Service Plan did not currently include physical therapy services. RDH/RN-C reiterated the need to have Service Plans signed each time the licensee made changes to the services and the points for the service changed.

On March 2, 2023, at 11:00 a.m. RN-B provided the surveyor with an amended area in the Service Plan to include the home health agency management of catheter needs and stated she will have the resident representative sign the

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Service Plan.

The licensee's Service Plan policy dated 2021, indicated a service plan is developed by the Registered Nurse based upon the uniform assessment. The RN provides a copy and reviews the plan with the resident/resident representative. Upon review the resident/ resident representative signs the service plan documenting agreement of the services to be provided. Signatures may include email/verbal documented consent.

No further information was provided.

TIME PERIOD FOR CORRECTION:
Twenty-One (21) days

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 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;

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(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 review, the licensee failed to ensure an individualized medication management plan included all required content for one of two 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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 26	01730		

situation has occurred only occasionally).

The findings include:

R2

R2's diagnoses included Alzheimer's disease, dementia with behavioral disturbance, anxiety, depression, myocardial infarction (heart attack), atrial fibrillation (when the heart has erratic heart rate), hypertensive kidney disease, hypertension (high blood pressure), neuromuscular dysfunction of the bladder (when the bladder no longer recognizes signals) with chronic presence of urinary catheter, hearing loss, wheezing, polymyalgia rheumatica, constipation, history of femur fracture, history of sepsis, dry eyes, and constipation.

R2's unsigned Service Plan dated January 13, 2023, indicated he received services to include medication administration.

On February 28, 2023, at 8:40 a.m. ULP-F was observed to administer six oral medications, one eye drop and a nebulizer.

R2's Medication Administration Record (MAR) dated February 2023, indicated he received one medication for pain, two supplements, one for depression, one for dementia agitation, one for wheezing, one for heart rate control, one for blood pressure, one for sleep, two for constipation, and one for dry eyes.

R2's Medication/Treatment/Therapy Plan integrated within R2's Service Plan dated January 13, 2023, indicated the licensee was managing R2's medications and treatment services.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32176	A. BUILDING: ______ B. WING ______	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICT HOUSE	**3883 19TH AVE NW ROCHESTER, MN 55901**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 27	01730		

R2's orders dated January 5, 2023, indicated the following orders for Seroquel (quetiapine):
-Seroquel 25 milligrams (mg) give 12.5 mg orally. Special Instructions: take one-half tablet (12.5 mg) by mouth once a day at 4:00 p.m.
-Seroquel 25 mg, give 12.5 mg orally. Special instructions: may have one PRN (as needed) dose in addition to scheduled dose as needed for aggressive behavior that is not redirected. As Needed; PRN-1; and
-quetiapine 25 mg, give 12.5 mg, Special Instructions: take one-half tab (12.5 mg) by mouth as needed; PRN-1, PRN-2, PRN-3

R2's record included two orders for PRN Seroquel and lacked specific instruction for how to space the timing for the three PRN doses from the scheduled dose and/or the other PRN dose.

On March 1, 2023, at 3:00 p.m. registered nurse (RN)-B stated the orders needed better clarification and she would reach out to the provider for specifics.

On March 2, 2023, at 11:00 a.m. RN-B provided the surveyor with a clinical note which indicated she had reached out to R2's provider for clarification.

The licensee's Medication Management Policy dated 2021, indicated the RN would provide documentation of specific resident instructions related to the administration of medications.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

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	32176	A. BUILDING: ______ B. WING ______	03/02/2023

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01820	Continued From page 28	01820		
01820 SS=D	144G.71 Subd. 13 Prescriptions	01820		

There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider managed for one of two residents (R1).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1's record lacked prescriber's orders for a medication administered by the facility.

R1's unsigned Service Plan dated January 13, 2023, indicated he received services to include medication set up and administration.

R1's medication administration record (MAR) dated February 2023, indicated he received Miralax (polyethylene glycol 3350) powder, once a day. Additionally in the Special Instructions area indicated, put 17 grams (gm) in 240 milliliters (ml)

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01820	Continued From page 29	01820		

of water two times per day as needed for constipation.

R1's medication orders dated December 12, 2022, indicated polyethylene glycol (Miralax), 17 gm/dose oral powder, take 17 gm by mouth daily for constipation, hold for loose stools.

R1's record lacked a signed prescriber's order to take Miralax two times daily as needed.

On March 1, 2023, at 2:45 p.m. registered nurse (RN)-B stated she would need to look further for the as needed orders.

On March 2, 2023, at 11:20 a.m. RN-B stated she was unable to find an order for the as needed dosing, and provided documentation of contact made that day with R1's provider.

The licensee's Medication and Treatment Orders, Receiving, Implementing, Renewal, and Re-ordering policy dated 2019, indicated a registered nurse would ensure that all medications and treatment orders either in writing, verbally, or electronically by an authorized provider are registered.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

01890 SS=D — 144G.71 Subd. 20 Prescription drugs — 01890

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

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01890	Continued From page 30	01890		

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 label a time sensitive medication with an opened date for one of two residents (R2) and failed to ensure stored medications were not expired for one of four residents (R5) with 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 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).

R2
R2's unsigned Service Plan dated January 13, 2023, indicated he received services to include medication administration.

R2's provider's orders dated January 3, 2023, indicated an order for Refresh tears drops; 0.5%; one drop in both eyes, three times a day as needed for dry eyes.

On February 28, 2023, at 8:15 a.m. unlicensed personnel (ULP)-F was observed to administer six oral medications and one eye drop medication. With review of R2's medication supply, the surveyor observed a bottle of Refresh eye drops with an attached label which indicated the need to enter the date the bottle was opened.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32176	A. BUILDING: ______ B. WING ______	03/02/2023

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01890	Continued From page 31 The label was blank without any indication of an opened date. ULP-F stated she was uncertain when the bottle would have been opened and stated, "I did not know it needed to be written on there." The eye drop packaging indicated "discard 90 days after opening." The licensee failed to ensure R2's bottle of eye drops included an open date. R5 R5's unsigned Service Plan dated January 13, 2023, indicated she received services to include medication administration. R5's provider's order report dated January 28, 2023 - January 28, 2023, indicated a start date of May 17, 2019, for Tums 500 mg; take five tablets orally at bedtime (HS), as needed for heartburn. On February 28, 2023, at 9:55 a.m. ULP-G was observed to administer oral medications to R5. The surveyor observed a bottle of Tums (antacid) in R5's medication supply with an expiration date of August 2019. ULP-G stated she had not noticed it was expired, but would pull the bottle out and alert the nurse. The licensee failed to ensure R5's medication had not exceeded the expiration date. On March 2, 2023, at 11:05 a.m. registered nurse (RN)-B stated staff were to write the date when time sensitive medications were opened, and the nurse was to complete a weekly medication storage audit to ensure medications were properly labeled as such. Additionally, RN-B stated the nurse was to complete weekly checks to include PRN (as needed) medications to	01890		

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01890	Continued From page 32 ensure there were no expired medications. The licensee's Storage of Medications policy dated 2018, indicated medications will be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02180 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (e) Behavioral symptoms that negatively impact the resident and others in the assisted living facility with dementia care must be evaluated and included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated. (f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly. (g) Existing housing with services establishments registered under chapter 144D prior to August 1, 2021, that obtain an assisted living facility license must provide residents with regular access to outdoor space. A licensee with new construction on or after August 1, 2021, or a new licensee that was not previously registered under chapter 144D prior to August 1, 2021, must provide regular access to secured outdoor space on the premises of the facility. A resident's access to outdoor space must be in accordance with the resident's documented care plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	02180		

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02180	Continued From page 33	02180		

review, the licensee failed to ensure behavioral symptoms were identified and were addressed on the care plan for one of two residents (R1).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1's diagnoses included Alzheimer's dementia (progressive mental deterioration) and major depressive disorder.

R1's unsigned Service Plan dated January 13, 2023, included the service of frequent/daily intervention for behaviors/depression/anxiety with a history of depression and medication administration.

On February 28, 2023, at 7:45 a.m. unlicensed personnel (ULP)-F was observed to provide stand by assistance with R1 as he ambulated with his walker from another resident's room to his room. ULP-F administered ten oral medications and one eye drop.

R1's nurse progress note (behavior note) dated December 30, 2022, read CNA (certified nursing assistant) reported that resident tried to strike her when she tried to redirect resident. Resident pushed another resident and was going into other rooms walking up residents.

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02180	Continued From page 34	02180		

R1's nurse progress note (behavior note) dated January 19, 2023, read RN notified by RA (resident assistant) that resident was walking alongside another resident in the hallway towards a room. This resident believed the other male resident was attempting to go to his wife. This resident got agitated and slapped the other resident's hand. RA witnessed event and immediately separated the residents and redirected this resident to an activity. No harm was inflicted to other resident, RN called provider and asked for additional interventions, waiting on update. Will continue to monitor.

R1's provider orders included:
-December 28, 2022, reduce mirtazapine (antidepressant) back to 7.5 milligrams (mg) daily at bedtime and start sertraline (antidepressant) 25 mg daily.
-January 26, 2023, increase Seroquel (quetiapine) to 25 mg daily in the early p.m. (4-5 p.m.) Monitor for oversedation or any acute (sudden) changes in his mood. Nursing will call Monday for update.

R1's medication administration record (MAR) dated February 2023, included sertraline 25 mg, one tablet daily; quetiapine 25 mg, one tablet daily; Melatonin 5 mg, one tablet daily at bedtime and mirtazapine 7.5 mg, one tablet daily.

R1's Resident Evaluation (assessment)/care plan dated January 13, 2023, in section identified as Behaviors/depression/anxiety-needs frequent/daily intervention as needed with note to include "report changes in behavior. History of depression. Utilize validation opposed to reality orientating as appropriate." Additionally, R1's Resident Evaluation (assessment)/care plan included areas of vulnerability which included,

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02180	Continued From page 35	02180		

"Has anxiety, depression, or mental illness" with the vulnerability description: history of depression. Intervention Plan: staff to administer fluoxitine and mirtazapine with the goal/outcome: Client will have minimal anxiety/depression and maintain functional daily activities.

The evaluation/care plan lacked specific behaviors/symptoms for depression and non-pharmacological interventions to implement for behavior management.

On March 1, 2023, at 3:00 p.m. registered nurse (RN)-B stated she would look for any indication of additional interventions for R1's known increased behaviors.

On March 2, 2023, at 11:00 a.m. RN-B stated she amended R1's Service Plan to include: Report changes to include redirect resident to room for quiet time, watching TV, offer toileting and/or snacks, walk with resident, call his wife. If non-pharmacological methods don't work call RN for PRN (as needed) Seroquel (no known order for PRN Seroquel).

The licensee's Behavioral Expression and Management policy undated, indicated Resident need for a behavior management plan is based on the resident's behavioral expressions and the risk of harm to self or others. Interventions for resident's behavioral expression are incorporated in the treatment/service Plan. Interventions are monitored and revised in needed. Documentation, in the resident's record, includes the resident's behavioral expressions, identified causal factor(s), interventions implemented, resident response to interventions and, if needed, communication with the family and physician/medical provider.

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02180	Continued From page 36 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02180		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *02/28/23*
Time: 11:27:38
Report: 8044231070

Food and Beverage Establishment Inspection Report

Location:
Benedict House - Main Kitchen
3883 19th Ave Nw
Rochester, MN55901
Olmsted County, 55

Establishment Info:
ID #: 0038948
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5072883911
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 previously issued on 02/28/23 have NOT been corrected.

3-500B Microbial Control: hot and cold holding

3-501.16A1 ** Priority 1 **

MN Rule 4626.0395A1 Maintain all hot, TCS foods at 135 degrees F (57 degrees C) or above. Roasts may be held at 130 degrees F (54 degrees C) or above if cooked or reheated in accordance with the specified time and temperature requirements in 4626.0340B.

Chicken in steam table measured at 120 degrees F.

Food reheated to 165 degrees F while on site.

Issued on: 02/28/23 *Comply By: 02/28/23*

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.

Grease and debris on sides and backsplash of grill and fryers.

Issued on: 02/28/23 *Comply By: 02/28/23*

Food and Beverage Establishment Inspection Report

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A1 ** Priority 1 **

MN Rule 4626.0395A1 Maintain all hot, TCS foods at 135 degrees F (57 degrees C) or above. Roasts may be held at 130 degrees F (54 degrees C) or above if cooked or reheated in accordance with the specified time and temperature requirements in 4626.0340B.

Chicken in steam table measured at 120 degrees F.

Food reheated to 165 degrees F while on site.
Comply By: 02/28/23

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.

Grease and debris on sides and backsplash of grill and fryers.
Comply By: 02/28/23

Surface and Equipment Sanitizers

Hot Water: = at 160.0 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40.1 Degrees Fahrenheit - Location: Milk in upright
Violation Issued: No

Process/Item: Hot Holding
Temperature: 119.8 Degrees Fahrenheit - Location: Chicken
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 40.3 Degrees Fahrenheit - Location: Pasta salad in WIC
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41.0 Degrees Fahrenheit - Location: WIC
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35.6 Degrees Fahrenheit - Location: Milk in upright 2
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 38.0 Degrees Fahrenheit - Location: Upright 2
Violation Issued: No

Process/Item: Cold Holding
Temperature: q Degrees Fahrenheit - Location:
Violation Issued: No

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

HRD inspection conducted with lead evaluator Deb Jacobson and Jodi Johnson. Inspection report reviewed on site with Gwen Frederick.

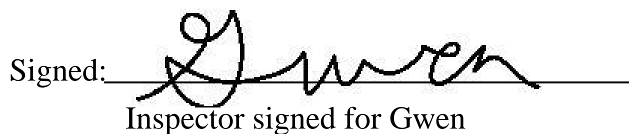
NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

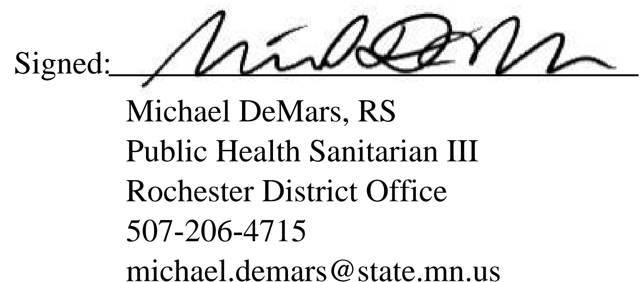
I acknowledge receipt of the Minnesota Department of Health inspection report number 8044231070 of 02/28/23.

Certified Food Protection Manager: Linda L. Jones

Certification Number: FM53277 Expires: 09/18/25

Inspection report reviewed with person in charge and emailed.

Signed: 
Inspector signed for Gwen

Signed: 

Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-206-4715
michael.demars@state.mn.us