Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 23, 2023

Licensee
Benedictine Living Community Northfield
2030 North Avenue
Northfield, MN 55057

RE: Project Number(s) SL35421015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 27, 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 . . ."

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

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after 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 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

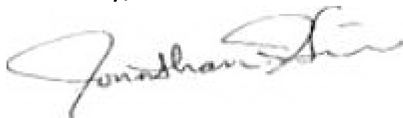
REQUESTING A HEARING

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. 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,



Jonathan Hill, Supervisor
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State Evaluation Team
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Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35421	A. BUILDING: ____ B. WING ____	01/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY N	**2030 NORTH AVENUE NORTHFIELD, MN 55057**

(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: SL35421015-0 On January 23 through January 27, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 76 active residents; 30 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 with Dementia Care 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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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Continued From page 1

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 to include appropriate use of gloves, and hand hygiene, for three of three employees (unlicensed personnel (ULP)-E, ULP-B, ULP-F).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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.)

The findings include:

ULP-E
On January 24, 2023, at 8:40 a.m., the surveyor observed ULP-E provide medication administration, which included oral and injectable medication administration without doffing (taking

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0 510	Continued From page 2 off) gloves and performing hand hygiene during medication administration. ULP-E washed hands with soap and water, and was observed to retrieve medications, prepare and scroll through R2's electronic medication administration record (eMAR) on a phone and verify medications. ULP-E donned (put on) a glove on the right hand, removed an analgesic gel container from medication storage bin. ULP-E brought medications and analgesic gel container to R2. ULP-E gave R2 the medication cup. R2 consumed medications and drank water from a personal cup. ULP-E lifted R2's right pant leg to expose right knee. ULP-E removed the cover of the analgesic cap using right gloved hand. ULP-E dispensed a small amount of gel onto right glove and applied gel to R2's right knee. After application, ULP-E placed analgesic gel cap onto container using gloved right hand. ULP disposed of medication cup and placed analgesic gel container back into medication bin. ULP-E removed glove on right hand, placed soiled glove into bathroom garbage, performed hand hygiene and donned clean gloves onto both hands. ULP-E removed insulin pen from medication storage container and compared label to eMAR. ULP-E removed an insulin pen needle from box in medication storage container, removed needle from protective container, wiped top of insulin pen with an alcohol wipe, and placed needle onto insulin pen. ULP-E primed the insulin pen by dispensing 2 units of insulin and proceeded to R2. R2 requested insulin be administered into buttock. R2 needed assistance with putting on right shoe and ULP-E bent down and with gloved hands assisted R2 by placing right shoe onto R2's right foot. ULP-E then assisted R2 with pulling pants down to expose buttock. Without changing gloves, ULP-E administered insulin from insulin pen into R2's buttock. R2 then pulled	0 510		

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0 510	Continued From page 3	0 510		

up pants. ULP-E returned to bathroom, removed needle from pen, and placed needle into sharps container. ULP-E returned insulin pen to medication storage container and without doffing gloves, documented medication administration on the eMAR. ULP-E removed gloves and placed into bathroom garbage. ULP-E then washed hands with soap and water appropriately.

ULP-B
On January 24, at 8:42 a.m., ULP-B was observed to check the blood glucose (BG) level and administer insulin to R1. ULP-B knocked and entered R1's apartment, performed hand hygiene using soap and water for 6 seconds, dried hands then shut water off using a paper towel. ULP-B accessed R1's eMAR using a portable device. ULP-B then checked R1's BG level using a remote sensor, and documented the result in the eMAR using a portable device. Without performing hand hygiene, ULP-B donned gloves, prepared R1's insulin pen, administered insulin, doffed gloves, then documented the administration in the eMAR. ULP-B exited R1's room then performed hand hygiene using hand sanitizer.

On January 24, 2023, at 8:50 a.m., ULP-B stated she had approximately two weeks of training upon hire, including hand hygiene training. ULP-B stated she was trained to wash with soap and water for 25 seconds, long enough to sing the happy birthday song. ULP-B further stated she was not sure if she washed long enough during the observation due to being nervous.

ULP-F
On January 24, 2023, at 9:12 a.m., the surveyor observed ULP-F provide medication administration without performing hand hygiene

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between residents. ULP-F knocked and entered R5's apartment. ULP-F washed hands with soap and water for 15 seconds. ULP-F unlocked R5's medication cabinet, and removed R5's medication storage container from the cabinet. ULP-F accessed R5's eMAR using a portable device, and prepared and administered medications to R5 and then documented the administration in R5's eMAR. ULP-F exited R5 apartment, and without performing hand hygiene, knocked and entered R4's apartment. ULP-F opened medication cabinet, and removed R4's medication storage container from the cabinet. ULP-F accessed R4's eMAR using a portable device, and prepared and administered medications to R4. Without performing hand hygiene, ULP-F donned gloves to both hands, applied a bandage to R4's right forearm, then doffed gloves. ULP-F performed hand hygiene using hand sanitizer after exiting R4's apartment.

On January 24, 2023, at 9:30 a.m., ULP-F stated that hand hygiene training was done yearly and staff were taught to wash hands with soap and water for 30 seconds. ULP-F stated she would do hand hygiene between passing medications to residents and before donning gloves. ULP-F acknowledged she was not sure if she completed hand hygiene between passing medications to R5 and R4.

On January 24, 2023, at 9:20 a.m., director of nursing (DON)-D stated all ULPs had been trained and instructed by the RN to wash hands after every donning or doffing of gloves. DON-D stated licensee conducted hand washing and glove use audits routinely.

The CDC guidance titled, Hand Hygiene in Healthcare Settings, dated January 8, 2021,

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0 510	Continued From page 5 indicated healthcare personnel (HCP) should perform HH before and after all patient contact, contact with potentially infectious material, and immediately before donning and after doffing gloves. The CDC indicated gloves should be changed and HH performed before moving from work on a soiled body site to a clean body site on the same patient. The CDC recommended alcohol-based hand sanitizer (ABHS) with 60% to 95% alcohol, or washing hands with soap and water for at least 15 seconds. The licensee's undated Hand Hygiene policy indicated hand washing would be completed before and after direct contact with a client and after removing gloves. The policy further indicated the procedure for washing hands with soap and water included rubbing soaped hands together for at least 20 seconds. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790		

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0 790	Continued From page 6	0 790		

This MN Requirement is not met as evidenced by:
Based on observation and interview, the licensee failed to maintain fire extinguishers in accordance with MN State Fire Code as required by MN Statute 144G.45 Subd.2 (a)(2). This had the potential to affect all current residents, staff, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

Findings include:

On January 26, 2023, at approximately 10:00 a.m., survey staff toured the facility with Licensed Assisted Living Director (LALD)-C, and Plant Operations Manager (POM)-H.
During the facility tour, it was observed that portable fire extinguishers were tagged showing the required annual service but lacked records to show the required monthly visual inspections were performed or recorded for all portable fire extinguishers located in the corridor throughout buildings.

During the facility tour, it was observed that the portable fire extinguishers in the laundry room on the first floor and the mechanical room on the second floor were missing the tags or labels from

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0 790	Continued From page 7 the certified service personnel indicating that annual maintenance had been performed. POM-H visually verified the findings at the time of discovery. No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
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, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 800		

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problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

Findings include:

On January 26, 2023, at approximately 10:00 a.m., survey staff toured the facility with Licensed Assisted Living Director (LALD)-C, and Plant Operations Manager (POM)-H. During the facility tour, survey staff observed the following:

It was observed that the exterior exit door located within the memory care sunroom on the first floor was sticking badly to the hollow metal frame, making it difficult to open.

It was observed that the exterior exit door located in the dining room on the first floor was sticking badly to the hollow metal frame, making it difficult to open.

It was observed that the vinyl tile flooring in the memory care dining room was bubbled and detached from the subfloor. The uneven tile finish created a tripping hazard for all residents. During the interview, POM-H stated that they were currently working with the tile installer, and the facility was going to add an area rug over the bubbled area for temporary protection.

The automatic door closer had been removed from the trash room in the basement. The door closer was required to ensure that the door will automatically close and latch to maintain the fire barrier from the adjacent room.

It was observed that the unit door was not closed automatically in resident room 131. The automatic door closer was removed and spring

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0 800	Continued From page 9 hinges were installed at the door jamb. The door was required to automatically close and latch to maintain the fire barrier from the corridor. The trash chute door on the first floor did not self-latch. The trash chute door should close and latch completely to maintain the fire resistance integrity of the trash chute system. POM-H visually verified the findings at the time of discovery. No further information provided 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	0 810		

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0 810	Continued From page 10	0 810		

readily available at all times within the facility.
(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.
(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to conduct the required evacuation drills. This had the potential to affect all staff, residents, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

Findings include:

An interview and record review of the available documentation were conducted on January 26, 2023, at approximately 10:00 a.m., with Licensed Assisted Living Director (LALD)-C, Nursing Administrator (DON)-D. on the fire safety and evacuation plan, fire safety and evacuation

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	35421	A. BUILDING: ______ B. WING ______	01/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY N	**2030 NORTH AVENUE NORTHFIELD, MN 55057**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 11 training for the facility, and fire safety and evacuation drills for the facility. A review of the Emergency Operations Plan provided by LALD-C indicated that a disaster drill was held every six months and fire disaster drills were held quarterly, not every other month as required by statute. The policy also did not make reference to the minimum requirement of twice per year, per shift. Provided documentation indicated that the drills were conducted on November 10, 2022 (2 p.m.), March 9, 2022 (7 a.m.), March 19, 2022 (2 p.m.), and November 11, 2021 (3 p.m.) with no further drills documented. The facility lacked documentation of two drills on the night shift and every other month as required by statute. LALD-C verified that there were no further documented drills for the facility and verified the deficient condition. No further information provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01310 SS=F	144G.60 Subd. 3 Licensed health professionals and nurses (a) Licensed health professionals and nurses providing services as employees of a licensed facility must possess a current Minnesota license or registration to practice. (b) Licensed health professionals and registered nurses must be competent in assessing resident needs, planning appropriate services to meet resident needs, implementing services, and supervising staff if assigned. (c) Nothing in this section limits or expands the rights of nurses or licensed health professionals	01310		

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NAME OF PROVIDER OR SUPPLIER: **BENEDICTINE LIVING COMMUNITY N**

STREET ADDRESS, CITY, STATE, ZIP CODE: **2030 NORTH AVENUE NORTHFIELD, MN 55057**

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01310	Continued From page 12	01310		

to provide services within the scope of their licenses or registrations, as provided by law.

This MN Requirement is not met as evidenced by:
Based on interview and record review the licensee failed to ensure a registered nurse (RN), who was providing services as an employee of the licensed facility, had a current Minnesota license or registration to practice, for one of four employees (RN-A), which had the potential to 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:

During the entrance conference on January 23, 2023, at 11:23 a.m., DON-D stated there were a total of four RNs employed by the licensee.

During record review on January 23, 2023, RN-A's employee file indicated they were hired on July 18, 2022. RN-A's employee file did not include a copy of RN-A's nursing license.

On January 23, 2023, the Minnesota (MN) Board of Nursing online licensure verification system indicated RN-A's registered nursing license expired October 31, 2022.

On January 23, 2023, at 1:40 p.m., DON-D stated she was not aware RN-A's nursing license had

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BENEDICTINE LIVING COMMUNITY N	**2030 NORTH AVENUE NORTHFIELD, MN 55057**

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expired. DON-D called RN-A, who stated she was not aware that her license had expired as she had renewed her license on the MN Board of Nursing online renewal website.

On January 23, 2023, at 2:30 p.m., DON-D supplied a copy of a receipt from the MN Board of Nursing showing RN-A had re-registered her RN nursing license on January 23, 2023. DON-D stated although RN-A thought she had renewed her RN license, it appeared she did not complete the process at that time.

On January 23, 2023, at 2:45 p.m., DON-D stated the human resource department for the licensee verified nursing licenses every quarter. DON-D also stated there was a system in place using the licensee's time clock system to verify if a licensed staff member had an expired license. DON-D stated if the licensed staff member's license was expired, they would not be able to clock in to work. DON-D further stated the licensee's time clock system was not working correctly as RN-A was able to clock in to work their scheduled shifts.

On January 24, 2023, at 8:24 a.m., RN-A stated she submitted her RN license renewal in October, and thought it was currently active. RN-A further stated she renewed her licensure again on January 23, 2023 (during the survey), at the request of the licensee, and would call the board of nursing later, regarding her previous renewal attempt. RN-A indicated she was on a leave of absence until approximately July 25, 2022, and had been working full time since her return and was unaware her RN license was expired. RN-A further stated she had been able to clock in normally and there was no indication of any concern regarding her license status.

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01310	Continued From page 14 The licensee's undated, Licenses and Certifications policy, indicated licensed employees were responsible to maintain licensure. The policy also stated a monthly report is sent to DON's and the DON's are responsible for reviewing the report and ensuring no licensed staff members with an expired license are scheduled to work. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01310		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained with the original prescription label with legible information for two of three residents (R2, 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number	01890		

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of staff are involved, or the situation has occurred only occasionally).

The findings include:

R2
On January 24, 2023, at approximately 8:40 a.m., the surveyor observed the contents of the locked medication cabinet and verified the contents with unlicensed personnel (ULP)-E.

R2's multivitamin dietary supplement bottle and R2's Biotin dietary supplement bottle, both lacked a label indicating who the medication was for as well as directions for medication administration.

On January 24, 2023, at 8:50 a.m., ULP-E stated she reviewed R2's medication administration record (MAR) for each of R3 dietary supplements. ULP-E stated she followed the MAR to determine the dosage to be given. ULP-E verified that the dietary supplement bottles matched the MAR.

R4
R4 was admitted December 10, 2019, began receiving assisted living services August 1, 2021, and received services including assistance with medication management.

R4's MAR from January 1 through January 24, 2023, indicated R4 was administered aspirin 81 milligrams (mg) 1 chewable tablet, by mouth every morning. The MAR further indicated R4 was ordered acetaminophen 325 mg one to two tablets every four hours as needed (prn) for pain, but the prn medication was not administered from January 1 through January 24, 2023.

On January 24, 2023, at approximately 9:19 a.m.,

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during a medication administration observation, ULP-F administered aspirin 81 mg, 1 tab to R4. ULP-F stated she followed the MAR to determine the medications to be administered and directions.

On January 24, 2023 at approximately 11:52 a.m., the surveyor observed R4's medication storage with licensed assisted living director (LALD)-C. R4's medication storage cabinet contained the following medication bottles lacking a label to indicate who the medication was for as well as administration directions: Extra strength Tylenol 325 mg, GenCare brand aspirin 81 mg, and Walgreens brand aspirin 81 mg. The cabinet also contained Reliable brand 81 mg aspirin bottle labeled with R4's name, but lacked resident administration directions. LALD-C verified the findings.

During interview on January 24, 2023, at 10:45 a.m., director of nursing (DON)-D stated over the counter medications such as dietary supplements may either be supplied by a resident's pharmacy or a family member. DON-D stated because the medications are kept locked in each residents room, the staff were able to verify that the bottles belonged to that resident. DON-D stated staff would access the electronic medical record to determine the prescribed dose to be given.

The licensee's undated Storage of Medication policy, indicated an over the counter medication must be kept in the original labeled container from the pharmacy or manufacturer. The policy further indicated prescribed medications must contain the original label with legible information stating the prescription number, name of resident, name of drug, and directions for use.

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01890	Continued From page 17 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure supplemental oxygen (O2) tanks were stored safely to prevent tipping. This had the potential to affect one of one resident (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 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: R4 received services including assistance with medication management and oxygen. R4's record included an order from the hospice provider for O2 to be administered via nasal	02310		

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02310	Continued From page 18	02310		

cannula (tubing delivering O2 via nostrils) at a rate of two liters (L) per minute as needed (prn).

On January 24, 2023, at 9:24 a.m., R4's room was observed to have three canister-style O2 tanks, in the closet, standing upright on the floor, and not secured to prevent tipping. Additionally, one O2 tank was standing upright, and secured in a wheeled cart to prevent tipping.

On January 24, 2023, at 9:24 a.m., although unlicensed personnel (ULP)-F stated the O2 tanks were always kept in R4's room, ULP-F stated she did not know how the O2 tanks were to be stored safely.

On January 24, 2023, at 9:38 a.m., registered nurse (RN)-A verified O2 tanks were stored in R4's apartment and hospice managed R4's O2 therapy. RN-A stated O2 tanks should be stored securely to prevent tipping. RN-A further stated she recalled seeing only one tank secured in a cart at her last weekly visit, and was not sure when R4 received additional O2 delivery. RN-A stated, "hospice or the O2 delivery company must have left the O2 tanks unsecured."

On January 24, 2023, at 9:50 a.m., director of nursing (DON)-D verified O2 tanks should be stored upright in racks. In addition, DON-D stated O2 was delivered directly to R4's apartment, and the ULP's would be expected to report to the RN, any improper storage.

On January 24, 2023, at 10:27 a.m., DON-D stated R4 last received O2 delivery on November 23, 2022. DON-D further stated the O2 tanks were "safely stored in [R4's] closet", and R4 did not use the O2 tanks or enter the closet where the tanks were stored.

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On January 24, 2023, at 10:37 a.m., a representative of R4's O2 supply company (RE)-G stated, via email, their policy was to follow the licensee's storage policy. RE-G further stated they would provide racks and cylinder holders, however the licensee was responsible for ensuring the O2 tanks were stored safely.

The licensee's Safe Oxygen Use and Storage (AL) policy, copyright 2019, indicated, "Residents are assessed to ensure their respiratory needs are being met. Residents identified in need or oxygen therapy have interventions/equipment implemented in accordance with the resident-centered service plan. 2. The nurse will ensure the resident has an appropriate storage cart or stand for the oxygen cylinder or oxygen concentrator and will educate the resident, the resident's family and resident's representative about safe use and storage of oxygen. 4. The RN will educate associates to be alert to any safety concerns related to the use and storage of oxygen consistent with the manufacturer's instructions. Associates will be trained to reinforce the client of safety concerns, take steps to eliminate the danger as quickly as possible, and report to the RN any use or storage of oxygen that is inconsistent with the manufacturer's directions."

Minnesota Department of Health guidance, Oxygen Cylinder Storage Requirements (based on the National Fire Protection Association, Standard 99 (NFPA 99), Health Care Facilities Code), dated April 16, 2020, indicated the types of hazards associated with oxygen as:
1) General fires and explosions enhanced by oxygen-rich atmospheres
2) Mechanical problems such as physical

Minnesota Department of Health

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02310	Continued From page 20 damage to compressed gas cylinders. The guidance further indicated, "when storing up to 300 cubic feet (ft^3) of oxygen, cylinders must be secured (chains or racks) to prevent them from falling over". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Type: Full
Date: *01/23/23*
Time: 13:12:18
Report: 1036231015

Food and Beverage Establishment Inspection Report

Location:
Benedictine Living Community N
2030 North Avenue
Northfield, MN55057
Dakota County, 19

Establishment Info:
ID #: 0037917
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 5076505022
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 171.1 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

LACTIC ACID & DDBSA: = 272/704 at Degrees Fahrenheit
Location: 3 COMP SINK DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/SLICED TOMATOES
Temperature: 40 Degrees Fahrenheit - Location: NORLAKE PREP COOLER TOP
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 40 Degrees Fahrenheit - Location: NORLAKE PREP COOLER BOTTOM
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 6 Degrees Fahrenheit - Location: NORLAKE REACH IN FREEZER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 38 Degrees Fahrenheit - Location: NORLAKE REACH IN COOLER IN BASEMENT
Violation Issued: No

Process/Item: Cold Hold/CHILI
Temperature: 36 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Ambient Temp
Temperature: 5 Degrees Fahrenheit - Location: WALK IN FREEZER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 38 Degrees Fahrenheit - Location: BEVERAGE REACH IN COOLER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS RENEE ANDERSON. INSPECTION CONDUCTED IN PRESENCE OF KITCHEN STAFF SARA, BRADY, AND PENNIE . ALL VIOLATIONS WERE DISCUSSED
WITH PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION.

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING:

- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- SANITIZER USE AND TEST KITS.
- HAND WASHING POLICY AND REVIEW.
- GLOVE USAGE
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING.
- PEST CONTROL.

**IF ANY RESIDENTS COMPLAIN OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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

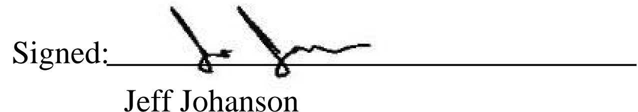
I acknowledge receipt of the inspection report number 1036231015 of 01/23/23.

Certified Food Protection Manager: SARA J. THOMAS

Certification Number: FM76701 Expires: 01/27/24

Inspection report reviewed with person in charge and emailed.

Signed:
SARA THOMAS
KITCHEN MANAGER

Signed: 
Jeff Johanson