Electronically Delivered

December 14, 2023

Licensee
Benedictine Living Community | Red Wing
135 Pioneer Road
Red Wing, MN 55066

RE: Project Number(s) SL20291015

Dear Licensee:

On November 22, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 29, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Electronically Delivered

November 1, 2023

Licensee
Benedictine Living Community | Red Wing
135 Pioneer Road
Red Wing, MN 55066

RE: Project Number(s) SL20291015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 29, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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 may be 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.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.

The MDH may impose 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 MDH 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 (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 survey:

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state correction 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

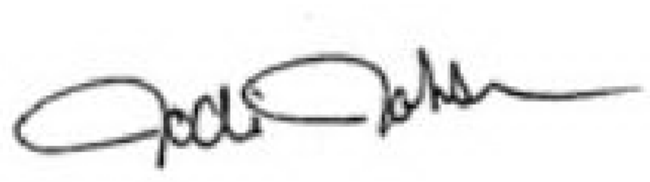
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH 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 the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20291	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

(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 SL20291015 On September 25, 2023, through September 29, 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 45 active residents; 42 receiving services under the Assisted Living with Dementia Care license. 1750: Immediacy was removed on September 29, 2023; however, non-compliance remains at a level 2/Widespread (F). 2310: Immediacy was removed on September 29, 2023; however, non-compliance remains at a level 3/Pattern (H).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated September 25, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=E	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	0 510		

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0 510	Continued From page 2 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 during treatments and medication administration for two of five unlicensed personnel (ULP-G, ULP-J). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-G began providing services under the Assisted Living with Dementia Care (ALFDC) license on August 1, 2021. On September 25, 2023, ULP-G was observed completing the following: - at 12:54 p.m., ULP-G was observed emptying R3's urinary catheter drainage bag. ULP-G put on gloves, retrieved the graduate from the bathroom, open the valve, drained the urine, and closed the valve. ULP-G failed to clean the valve prior to closing it. ULP-G then emptied and rinsed the graduate, removed her gloves and exited the	0 510		

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0 510	Continued From page 3 room. ULP-G returned to the medication cart, used hand sanitizer, and began setting up medications. ULP-G failed to wash her hands. - At 1:13 p.m., ULP-G set up medications for R2. ULP-G went to R2's room to administer medications. During administration of the medications, ULP-G noted R2's ostomy device was leaking and needed to be replaced. - At 1:28 p.m., ULP-G and licensed practical nurse (LPN)-E put on gloves and assisted R2 to the bathroom and had him sit on the toilet. ULP-G began cleaning the stool from the skin surrounding the colostomy device using disposable wipes. LPN-E removed the colostomy device. ULP-G continued to clean the ostomy site and the skin surrounding the ostomy. LPN-E removed gloves, washed hands, placed clean gloves, and applied a new colostomy device. ULP-G removed soiled gloves and placed clean gloves. ULP-G failed to wash hands. ULP-G removed R2's soiled, incontinent brief and pants and placed a clean brief and pants on R2's lower legs. ULP-G and LPN-E assisted R2 to standing position and noted stool in the peri area. ULP-G cleaned the area with disposable wipes and then a washcloth with cleanser. ULP-G and LPN-E then pulled up R2's brief and pants. R2 sat down to rest prior to returning to the recliner. ULP-G took garbage containing the soiled colostomy device, disposable wipes, and soiled gloves out of the bathroom and put it by the door. ULP-G removed gloves and applied clean gloves. ULP-G failed to wash their hands. LPN-E and ULP-G assisted R2 to his recliner. During the transfer, R2's water tumbler fell onto the floor. LPN-E removed gloves, washed hands, put on gloves, picked up the garbage, and exited the room. ULP-G removed gloves and without washing their hands, ULP-G picked up the water tumbler from the floor, opened the tumbler using	0 510		

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0 510	Continued From page 4 one hand on the cap of the tumbler and one hand on the tumbler, emptied it into the sink, got an ice tray from the freezer, put a glove on the right hand, put ice in the bottle using the gloved hand, removed the glove, filled the tumbler, closed it by using one hand on the top of the tumbler and one hand on the tumbler, and set it next to R2. ULP-G washed her hands and exited the room. On September 25, 2023, at 2:23 p.m. director of nursing services (DNS)-D stated ULP-G should have washed her hands after cleaning stool from R2 and glove removal, prior to filling R2's water tumbler. At 3:30 p.m., DNS-D further stated ULP-G should have used an alcohol prep pad on the urinary drainage bag valve when closing the valve. Staff were expected to wash their hands after they removed their gloves and if their hands were visibly soiled. ULP-J ULP-J began providing services under the Assisted Living with Dementia Care (ALFDC) license on August 11, 2023. On September 25, 2023, at 1:30 p.m. ULP-J applied gloves, assisted R15 to the bathroom and removed the gloves once the task was completed. ULP-J then applied new gloves to complete wound care. ULP-J did not wash their hands between glove removal and applying new gloves. On September 26, 2023, at 9:34 a.m. DNS-D stated the expectation was to wash hands before and after using gloves. The licensee's Skills Competency for Catheter Care dated 2022, included the following steps: "7. Empty drainage bag when full.	0 510		

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0 510	Continued From page 5 8. Place a large container or graduate on the floor -or you may empty bag into toilet. 9. Without touching tip, remove drain spout from sleeve at bottom of urine bag. Open slide valve on the spout. 10. Let urine flow out of bag into container or toilet. Do not let drainage tube touch anything. 11. When bag is empty, clean end of drain spout with alcohol swab. Close slide valve and put the drain spout into its sleeve at the bottom of urine bag." The licensee's Procedure for Using Gloves dated March 3, 2022, identified the following steps: "1. Wash Hands 2. Apply gloves to both hands 3. Complete task. If gloves become torn or heavily soiled and additional tasks must be performed for the client, then change the gloves (washing hands before putting on new gloves before starting the next task. 4. Place any contaminated materials in proper receptacle - such as biohazardous waste for wound care dressings. 5. Remove gloves by grasping cuff of one glove and pulling it off, turning it inside out. With ungloved hand tuck finger inside cuff of remaining glove and pull off, turning inside out with first glove inside the second glove. 6. Dispose of used gloves in proper receptacle - biohazardous if they have contaminated material on them. 7. Rewash hands." The licensee's Hand Hygiene policy dated March 3, 2022, identified the following: "Hand-washing, which is the single most effective way of controlling the spread of infection, will be performed by staff routinely and thoroughly to	0 510		

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0 510	Continued From page 6 protect residents from the spread of infection." "1. When Hands Should be Washed. Hand washing shall be performed between client cares and whenever direct physical contact with a client takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: a. Before and after direct contact with a client b. If moving from a contaminated-body site to a clean-body site during client care c. After contact with environmental surfaces or equipment in the immediate vicinity of the client d. After removing gloves or gowns" No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs;	0 650		

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0 650	Continued From page 7 (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of two employees (unlicensed personnel (ULP)-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 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-F was hired under the comprehensive home care license on May 19, 2021, and began providing services under the assisted living with dementia care license on August 1, 2021. On September 25, 2023, at 12:34 p.m. ULP-F was observed administering medications to R7. ULP-F's employee record lacked evidence of a job description or an annual performance evaluation. On September 28, 2023, at 4:29 p.m. registered nurse/licensed assisted living director (RN/LALD)-C, licensed assisted living director in	0 650		

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0 650	Continued From page 8 residency (LALDIR)-B, and director of nursing services (DNS)-D stated ULP-F's employee record did not have a job description or annual performance evaluation, therefore it had not been completed. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 800 SS=D	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) and was issued at an isolated scope (when one or a limited number of	0 800		

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0 800	Continued From page 9 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On facility tour with Maintenance Staff (MS)-M, Environmental Services Director (EVSD)-L, and Assisted Living Director (ALDIR)-B between approximately 8:30 a.m. and 12:45 p.m. on September 27, 2023, it was observed that the trash chute door on the 3rd floor did not close and positively latch as required as part of the fire rated shaft assembly. Additionally, the resident in Room 211 uses oxygen within her room but no sign indicating this is displayed. These deficient conditions were visually verified by MS-M, EVSD-L, and ALDIR-B accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable.	0 900		

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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
0 900	Continued From page 10 (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written contract prior to providing assisted living services for one of four residents (R2) with record reviewed. 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:	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20291	A. BUILDING: _____ B. WING _____	09/29/2023

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0 900	Continued From page 11 R2 was admitted under the comprehensive home care license on August 17, 2020, and began receiving services under the assisted living license on August 1, 2021. R2's record identified a Residency Agreement dated August 17, 2020. R2's record lacked evidence an assisted living contract had been signed. On September 28, 2023, at 11:20 a.m. licensed assisted living director in residency (LALDIR)-B stated R2's record failed to have a signed assisted living contract and only contained the previously used residency agreement that was used under the comprehensive home care license. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider;	01060		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

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01060	Continued From page 12 (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 to one of one resident (R1) with three hospitalizations. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01060		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

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01060	Continued From page 13 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted under the assisted living licensure on August 1, 2021, with diagnoses including anxiety, diabetes (chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces), falls, and glaucoma (eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye called the optic nerve). R1's progress notes identified the following: - June 20, 2023, at 11:55 a.m. "Tenant transported to [hospital] ER [emergency room] at 1130 on 06/19/2023, d/t [due to] increased confusion, increased unsteady gait. Son was here and is in agreement with transfer." - June 21, 2023, at 1:39 p.m. "Readmission: Tenant discharged hospital at 12:15 p.m. transported to facility via RWM, and escorted to apt [apartment] in wheelchair." - June 28, 2023, at 12:40 p.m. "Tenant sent out via ambulance r/t decreased cognition, non-weight bearing status and fall." R1's Notice of Emergency Relocation dated June 22, 2023, failed to identify: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (4) if known and applicable, the approximate date	01060		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

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01060	Continued From page 14 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. R1's record lacked evidence the Notice of Relocation had been provided to R1 or her designated representative as soon as practicable. R1's Notice of Emergency Relocation dated June 27, 2023, failed to identify: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (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. R1's record lacked evidence the Notice of Relocation had been provided to R1 or her designated representative as soon as practicable. On September 27, 2023, at 9:35 a.m. registered nurse/licensed assisted living director (RN/LALD)-C stated the emergency transfer form lacked the required content and all emergency transfers would be missing the required content. RN/LALD-C stated the resident was given a copy of the emergency transfer form but there was no	01060		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

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BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

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01060	Continued From page 15 documentation the forms had been provided to R1, or the designated representative. The licensee's undated, Emergency Relocation Checklist identified "When a facility takes any action that results in the resident leaving the facility (e.g. hospitalization or other inpatient admission), the facility must deliver a written notice to the resident, their legal representative and their designated representative. Also send the notice to the resident's case manager if they are receiving home and community-based waiver funds". "Deliver written notice as soon as possible (hand delivery to resident or representative or e-mail to representative are acceptable)." "Deliver the notice to the Office of Ombudsman for Long Term Care if resident has not returned to the facility within four days". "Deliver written notice as soon as possible and within 24 hours." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal	01370		

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01370	Continued From page 16 hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-F) completed training and competency evaluations in all required training topics. 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	01370		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

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01370	Continued From page 17 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-F was hired under the comprehensive home care license on May 19, 2021, and began providing services under the assisted living with dementia care license on August 1, 2021 On September 25, 2023, at 12:35 p.m. ULP-F was observed administering oral medications to R7 and R8. ULP-F's employee file lacked evidence of training and/or competencies in the following topics - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - dressing and assisting with toileting; - standby assistance techniques and how to perform them; and - medication, exercise, and treatment reminders. On September 28, 2023, at 4:29 p.m. registered nurse/licensed assisted living director (RN/LALD)-C, licensed assisted living director in residency (LALDIR)-B, and director of nursing services (DNS)-D stated ULP-F's employee record lacked evidence of the required training and competencies listed and they were unable to locate it. They further stated all staff should have the required training and competencies.	01370		

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01370	Continued From page 18 The licensee's Orientation policy dated March 4, 2024, identified: "1. The immediate supervisor is responsible to ensure that proper orientation procedures and documentation are completed. 2. The supervisor will schedule general orientation to begin immediately upon hire of all new employees and be completed within the specified time frame. 3. Employees should not perform job duties before the completion of orientation to the job including general and safety orientation. 4. An orientation checklist will be completed by the employee and trainer, signed by each person, and will be filed in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and	01380		

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01380	Continued From page 19 (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-F) completed training and competency evaluations in all required training topics. 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: ULP-F was hired under the comprehensive home care license on May 19, 2021, and began providing services under the assisted living with dementia care license on August 1, 2021. On September 25, 2023, at 12:35 p.m. ULP-F was observed administering oral medications to R7 and R8. ULP-F's employee file lacked evidence of training and/or competencies in the following topics: - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required.	01380		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

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01380	Continued From page 20 On September 28, 2023, at 4:29 p.m. registered nurse/licensed assisted living director (RN/LALD)-C, licensed assisted living director in residency (LALDIR)-B, and director of nursing services (DNS)-D stated ULP-F's employee record lacked evidence of the required training and competencies listed and they were unable to locate it. They further stated all staff should have the required training and competencies. The licensee's Orientation policy dated March 4, 2024, identified: "1. The immediate supervisor is responsible to ensure that proper orientation procedures and documentation are completed. 2. The supervisor will schedule general orientation to begin immediately upon hire of all new employees and be completed within the specified time frame. 3. Employees should not perform job duties before the completion of orientation to the job including general and safety orientation. 4. An orientation checklist will be completed by the employee and trainer, signed by each person, and will be filed in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the	01620		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

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BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

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01620	Continued From page 21 resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 days from the last assessment for one of three residents (R15). 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:	01620		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

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01620	Continued From page 22 R15 started receiving services on December 14, 2018, with a diagnosis of dementia with behavior disturbance, and major depressive disorder. R15's service plan dated August 15, 2022, indicated R15 received medication management and assistance with activities of daily living (ADLs). R15's record included the following comprehensive assessments dated: -February 24, 2023; -May 24, 2023 (89 days from the previous assessment); and -August 28, 2023 (96 days from the previous assessment, six days overdue) On September 28, 2023, at 2:00 p.m. registered nurse (RN)-C confirmed R15's August 2023, assessment was 96 days old and was aware assessments were required to be completed no more than 90 days from the previous assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications,	01750		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

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01750	Continued From page 23 and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of four unlicensed personnel (ULP-F) completed training and demonstrated competency to a registered nurse (RN) for medication administration. This had the potential to affect all residents receiving medication administration. This resulted in an immediate correction order identified on September 28, 2023, at 4:29 p.m. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-F began providing services under the Assisted Living with Dementia Care (ALFDC) license on May 19, 2021. On September 25, 2023, at 12:35 p.m. ULP-F was observed administering oral medications to R7 and R8.	01750		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01750	Continued From page 24 ULP-F's employee file lacked evidence of demonstrating competency for medication administration to a RN. On September 28, 2023, at 4:29 p.m. registered nurse/licensed assisted living director (RN/LALD)-C, licensed assisted living director in residency (LALDIR)-B, and director of nursing services (DNS)-D stated ULP-F's employee record lacked evidence of demonstrating competency for medication administration and they were unable to locate it. They further stated all staff should have medication administration competencies by a RN completed prior to administering medications. In addition, RN/LALD-C stated ULP-F separated employment effective today. The licensee's Medication, Treatment, and Therapy Administration-Licensed and Unlicensed Personnel policy dated March 3, 2022, read "1. Training and Competency of ULP: A. A RN instructs the ULP on the following medication administration tasks, according to the resident's service plan, before delegating the task to them: a. The complete procedure of checking a resident's medication administration record (MAR) b. The preparation of medication for administration c. The administration of the medication to the resident d. The reminder to self-administer medications e. The documentation after assistance with medication reminder or medication administration, including the date, time, dosage, and method of administration of all medications. If not administered, the reason for not assisting	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20291	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

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01750	Continued From page 25 with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same. B. The ULP demonstrates their ability to competently follow the delegated medication administration to a RN. C. Written records, signed by a RN, shall be maintained regarding ULP training and competency testing of delegated medication, treatment, or therapy administration." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On September 29, 2023, at 8:28 a.m. the immediacy was removed based on observations by the surveyor and record reviews by the evaluation supervisor; however, non-compliance remains at a scope and level of F. Based on observation, interview and record review, the licensee failed to ensure one of one ULP (ULP-I) followed manufacturer directions with insulin administration from an insulin pen and failed to check blood glucose prior to insulin administration for R10. On September 25, 2023, at 7:15 a.m. ULP-I was observed administering Lantus and Novolog (diabetic injectable medications) to R10. ULP-I removed the Lantus insulin pen from the medication cart, turned the dial to 2, pushed the button in, and dialed the pen to 35. ULP-I then cleaned the port and placed the needle onto the pen. ULP-I removed the Novolog insulin pen from the medication cart, turned the dial to 2, pushed the button in, and dialed the pen to 12 units.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20291	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

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01750	Continued From page 26 ULP-I then cleaned the port and placed the needle onto the pen. ULP-I then administered the medications to R10. After administration of the insulin, ULP-I checked the R10's blood glucose. On September 26, 2023, director of nursing services (DNS)-D stated ULP-I should have checked the blood glucose prior to administering insulin in case the blood sugar was low, which would require holding the insulin. DNS-D stated the air shot should be performed after the needle is placed on the insulin pen and it defeats the purpose of priming the needle if completed prior to placing the needle. Staff were trained to check blood sugar prior to administration of insulin and they were trained to complete the air shot after the needle was put on to the insulin pen. The licensee's undated, procedure for insulin pens identified: 1. Check the MAR for type and dosage of insulin. 2. Verify that bottles are dated when opened. 3. Explain to the client what you are going to do. 4. Wash your hands. 5. Select a site with fatty tissue. Make sure the site is clean. If not, wipe with moist cloth or cotton ball. 6. Check the expiration date and type of insulin if you have more than one type of pen. 7. Remove the pen cap and clean the tip with sterile alcohol wipe. 8. Attach a new needle to the pen. 9. Prime the pen and then dial up the correct dose. Double-check the dose before injecting. 10. Inject the insulin using good injection technique. Lantus SoloStar pen prescriber information dated November 2018, identified the following steps for	01750		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

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01750	Continued From page 27 administering insulin with the pen: Step one - check the pen Step two - attach the needle Step three - perform a safety test, which included the following information Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by ensuring that pen and needle are working properly and removing air bubbles. A. Select a dose of 2 units by turning the dosage selector. B. Take off the outer needle cap and keep it to remove the used needle after injection. Take of the inner needle cap and discard it. C. Hold the pen with the needle pointing upwards. D. Tap the insulin reservoir so that any air bubbles rise up towards the needle. E. Press the injection button all the way in. Check if insulin comes out the needle tip. You may have to perform the safety test several times before insulin is seen - If no insulin comes out, check for air bubbles and repeat the safety test two more times to remove them. - If still no insulin comes out, the needle may be blocked. Change the needle and try again. - If no insulin comes out after changing the needle, your SoloStar may be damaged. Do not use this SoloStar. Step 4 - Select the dose. Step 5 - inject the dose. Step 6 - remove and discard the needle. Novolog prescribing information dated February 2015, identified the following steps: Step 1 - pull the pen cap off Step 2 - Check the liquid in the pen Step 3 - Select a new needle and pull off the	01750		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

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01750	Continued From page 28 paper tab Step 4 - Push the capped needle straight onto the pen and twist the needle on until it is tight Step 5 - Pull off the outer needle cap Step 6 - Pull off the inner needle cap and throw it away Priming your NovoLog FlexTouch pen Step 7- Turn the dose selector to select 2 units Step 8 - Hold the pen with the needle pointing up. Tap the top of the pen gently a few times to let any air bubbles rise to the top Step 9 - Hold the pen with the needle pointing up. Press and hold in the dose button until the dose counter shows "0". The "0" must line up with the dose pointer. A drop of insulin should be seen on the needle tip. - If you do not see a drop of insulin, repeat steps 7 to 9, no more than 6 times. - If you still do not see a drop of insulin, change the needles and repeat steps 7 to 9. Step 10 - Turn the dose selector to select the number of units you need to inject. Step 11 - Choose your injection site and wipe the skin with an alcohol swab. Step 12 - Insert the needle into your skin Step 13 - Press and hold down the dose button until the dose counter shows "0". Step 14 - Pull the needle out of you skin Step 15 - Carefully remove the needle from the pen and throw it away. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20291	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

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01760	Continued From page 29 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for four of seven residents (R8, R4, R2, and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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: R8 On September 25, 2023, at 12:43 p.m. unlicensed personnel (ULP)-F was observed administering R8's medications which included two tablets in a pre set up box, according to the electronic medication administration record	01760		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

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01760	Continued From page 30 (MAR) was acetaminophen 500 mg two tablets four times a day. R8's MAR dated September 1, 2023, through September 26, 2023, identified R8 had received acetaminophen 500 mg two tablets four times a day at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. R8's after visit summary dated August 1, 2023, identified current medication as acetaminophen 500 mg take two tablets by mouth every six hours. On September 27, 2023, at 2:28 p.m. registered nurse/licensed assisted living director (RN/LALD)-C stated R8's acetaminophen was a medication error because the acetaminophen was not administered every six hours as ordered. R4 On September 26, 2023, at 7:55 a.m. ULP-H was setting up medications for administration for R4. ULP-H took a bottle of MetaMucil sugar free 4 in 1 powder from the medication cart. The MetaMucil had R4's name and room number hand written on it. ULP-H used a measuring cup to measure out the powder and stated the order is 2.4 grams so she filled the measuring cup between the 2.5 and the 5 ml (milliliter) marks. The surveyor asked her to clarify if that was the same measurement since she stated grams but the marks were in millimeter. ULP-H looked up a conversion and stated that it was correct. ULP-H then began to set up the other medications. The surveyor intervened and pointed out on the electronic medication administration record, it had a section for special instructions which identified "Mix 1 teaspoon in 6-8 fluid ounces of water twice a day." ULP-H stated "that is my fault, I should	01760		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

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01760	Continued From page 31 have looked at the special instructions and corrected the amount in the medication cup to one teaspoon." R4's MAR dated September 1, 2023, through September 26, 2023, identified Metamucil Sugar-Free powder 3.4 gram/5.8 gram oral twice daily with special instructions of "Mix 1 teaspoon in 6-8 fluid ounces of water twice a day." R4's physician orders dated January 16, 2023, identified MetaMucil Sugar-Free powder 3.4 gram/5.8 gram oral twice daily with special instructions of "Mix 1 teaspoon in 6-8 fluid ounces of water twice a day." On September 26, 2023, at 9:34 a.m. director of nursing services (DNS)-D stated R4's MetaMucil should have been administered as ordered and she would check the MAR to assure the directions were clear. R2 On September 25, 2023, at 2:19 p.m. unlicensed personnel (ULP)-G was observed administering Excedrin Extra Strength one tablet orally every 12 hours as needed for headache to R2. R2's MAR dated September 1, 2023, through September 25, 2023, identified R2 had received Excedrin Extra Strength one tablet orally every 12 hours as needed for headache, and had been administered less than 12 hours apart on two separate occasions: - September 8, 2023, administered at 11:37 a.m. and 9:01 p.m. - this was 9 hours and 24 minutes between doses. - September 13, 2023, administered at 8:44 a.m. and 3:37 p.m. - this was 6 hours and 53 minutes between doses.	01760		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01760	Continued From page 32 R2's physician orders dated February 27, 2023, identified Excedrin Extra Strength give one tablet orally every 12 hours as needed for headache. R3 R3's MAR dated September 1, 2023, through September 25, 2023, identified omeprazole 20 mg orally once a day, give before breakfast. The omeprazole was scheduled at 8:00 a.m. with his other morning medications. In addition, the omeprazole had been administered after 9:00 a.m. on six different occasions. On September 28, 2023, at 8:00 a.m. DNS-D stated the R3's omeprazole had not been administered before breakfast as ordered and she had contacted the provider to change the order to evening to avoid interaction with another early morning medication. On September 28, 2023, at 2:51 p.m. RN/LALD-C stated medications should be administered as ordered. The licensee's Medication, Treatment, and Therapy Administration -Licensed and Unlicensed Personnel policy dated March 3, 2022, identified "Medication, treatment, or therapy will be administered as directed by the resident's Provider orders, the service plan and MAR." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=E	144G.71 Subd. 13 Prescriptions	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20291	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01820	Continued From page 33 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 interview and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider had managed for five of six residents (R2, R3, R8, R10, and R17). 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: R2 R2's service plan dated June 30, 2023, identified R2 received medication management and administration services. On September 25, 2023, at 1:13 p.m. unlicensed personnel (ULP)-G was observed administering medications to R2, which included: - acetaminophen (pain reliever) 500 milligrams (mg) two tablets by mouth three times a day; and - gabapentin (nerve pain reliever) 300 mg two capsules by mouth at 2:00 p.m.	01820		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01820	Continued From page 34 R2's Medication administration record (MAR) dated September 1, 2023, through September 25, 2023, indicated the following medications had been administered: - acetaminophen 500 mg two tabs by mouth three times a day; - gabapentin 300 mg two capsules orally twice a day at 2:00 p.m. and 8:00 p.m.; and - gabapentin 300 mg three capsules orally once a day at 7:30 a.m. R2's annual physician orders signed February 27, 2023, included the following: - acetaminophen 500 mg two tabs by mouth two times a day; and - gabapentin 300 mg take 1 capsule with gabapentin 400 mg 1 capsule to equal 700 mg by mouth twice daily. Orders obtained from the pharmacy on September 26, 2023, after requested by the surveyor identified: - acetaminophen 500 mg two tabs by mouth three times a day was last ordered on September 14, 2023. - gabapentin 300 mg take 3 capsules by mouth every morning, take 2 capsules by mouth twice daily afternoon and evening was last ordered August 21, 2023. Orders obtained from outside hospice agency on September 27, 2023, at 12:58 p.m., after requested by surveyor, identified the following: - order on April 14, 2023, to discontinue the acetaminophen twice a day and begin acetaminophen 500 mg two tabs by mouth three times a day. - order on June 28, 2023, to discontinue the current gabapentin dose and begin gabapentin	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20291	A. BUILDING: _____ B. WING _____	09/29/2023

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BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

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01820	Continued From page 35 300 mg take 3 capsules by mouth every morning, take 2 capsules by mouth twice daily afternoon and evening. On September 27, 2023, at 9:35 a.m. director of nursing services (DNS)-D stated she obtained the acetaminophen and gabapentin orders from the pharmacy on September 26, 2023. The orders were from hospice. The facility did not have the orders in R2's record prior to the surveyor's request for orders. On September 27, 2023, at 1:45 p.m. registered nurse/licensed assisted living director (RN/LALD)-C stated they accessed the hospice portal and printed the orders for R2. They did not have those orders in R2's record prior to the surveyor's request. R3 R3's service plan dated August 22, 2023, identified R3 received medication management and administration services. R3's MAR dated September 1, 2023, through September 25, 2023, included: - lisinopril (treats blood pressure) 40 mg by mouth once a day had been received September 1-5, 2023; and - lisinopril 20 mg by mouth once a day had been received September 6-25, 2023. R3's physician orders dated August 17, 2023, (prior to resident admission) identified an order for: - lisinopril 40 mg by mouth once a day. R3's admission orders dated August 22, 2023, identified: - lisinopril 40 mg by mouth once a day.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20291	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01820	Continued From page 36 R3's unsigned, after visit summary dated September 1, 2023, identified R3's current medications included: - lisinopril 20 mg by mouth daily. It failed to identify lisinopril 40 mg by mouth daily which R3 had been taking. On September 18, 2023, at 8:00 a.m. DNS-D stated she used the unsigned, after visit summaries or prescription bottles as physician orders at times. R3's order was changed based on the unsigned, after visit summary on September 1, 2023. R8 On September 25, 2023, at 12:43 p.m. ULP-F was observed administering R8's medications which included two tablets in a preset up box, according to the electronic MAR was acetaminophen 500 mg two tablets four times a day. R8's medication administration record dated September 1, 2023, through September 26, 2023, identified R8 had received acetaminophen 500 mg two tablets four times a day at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. R8's physician orders dated May 10, 2023, identified acetaminophen current order was 500 mg by mouth every six hours as needed for pain. The provider wrote "If negative [lab test] then I would recommend taking Tylenol in the morning and evening." On September 27, 2023, at 11:30 a.m. DNS-D stated the order was changed at an appointment and R8's family member had a copy of the order and was bringing it in to the facility.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20291	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

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01820	Continued From page 37 On September 27, 2023, at 1:45 p.m. RN/LALD-C stated they had received the after-visit summary from R8's family member and provided it to the surveyor. R8's after visit summary dated August 1, 2023, identified current medication as acetaminophen 500 mg take two tablets by mouth every six hours. R10 On September 25, 2023, at 7:15 a.m. ULP-I was observed administering the following medications to R10: - Lantus (long acting insulin) 35 units subcutaneously; and - Novolog (short acting insulin) 12 units subcutaneously. R10's service plan dated November 11, 2021, identified R10 received medication management and assistance with activities of daily living (ADLs). R10's MAR dated September 1, 2023, through September 25, 2023, identified the above medication was administered. R10's record failed to show evidence of a physician order for the current medication. On September 27, 2023, at 2:35 p.m. RN-C stated they did not have physician orders for R10's medication. R17 On September 25, 2023, at 8:30 a.m. ULP-J was observed administering R17's morning	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20291	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

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01820	Continued From page 38 medications which included: -Amantadine (can treat Parkinson's disease and flu like symptoms) 100 mg -Comtan (treats Parkinson's disease) 200 mg -Sinemet (for Parkinson's disease) 25-100 mg 1.5 tablets -Vitamin B-12 (supplement) 500 micrograms (mcg) -Senna (stool softener) two tablets R17's September 2023, MAR identified ULP-J administered the above medications. R17's record failed to show evidence of a physician order for the Vitamin B-12 mcg. On September 27, 2023, at 3:39 p.m. RN-C stated they did not have signed orders for the Vitamin B-12. RN-C further stated annual orders were completed in February 2023, and Vitamin B-12 was new and an order was not obtained. The licensee's Medication & Treatment Orders - Receiving, Implementing, Renewal and Re-ordering policy dated August 1, 2021, identified: " A licensed nurse, licensed therapist or pharmacist ensure that medications and treatment orders (either in writing, verbally, or electronically) by an authorized provider are transcribed into the medical record." "Requesting and receiving provider prescriptions for medications. a) All orders for medications and treatments must be dated and signed by the provider and will be current and consistent with the nursing assessment. b) When new medication prescriptions are sent directly to the pharmacy by the provider or	01820		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

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01820	Continued From page 39 resident, the licensed nurse will request a copy of the prescription from the provider or from the pharmacy. c) When medication prescriptions are initiated by another health care provider, i.e., hospice or home care, the licensed nurse will request a copy of the prescription signed by a provider. d) Content of medication or treatment orders will contain: a. The date of issue b. Name and address of the resident c. Name and quantity of the drug prescribed. d. Dosage, frequency, route, and indication for use of medication e. Name and address of the prescriber and a telephone number where the prescriber can be reached. f. The prescriber ' s manual or electronic signature e) Verbal orders received from a provider: a. Will be received by a licensed nurse or pharmacist. b. Licensed nurse will receive and transcribe the order into the medical record. c. Licensed nurse will forward the written order to the provider for signature through mail, onsite visit or electronically. f) Electronically transmitted orders: a. An order received by telephone, facsimile machine, or other electronic means will be received and kept confidential and communicated to the licensed nurse in a timely manner. b. Once received, the order will be recorded and placed in the resident's record by the licensed nurse. c. An order received by email or facsimile machine will be signed by the provider. g) When appropriate, medication or treatment order changes will be made in the resident ' s Service Plan by the RN.	01820		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

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BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

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01820	Continued From page 40 h) In order to keep medication, order up to date, the licensed nurse will provide a list of current medications to the resident to bring to all medical appointments. i) Prescribed and non-prescribed medications or treatments will require a prescription from the health care provider. The resident or resident ' s representative will be informed of the requirement for a prescription for all over the counter and dietary supplements. Without the prescription, the community cannot agree to manage the medications. j) When medications are provided by residents or family members or if the associates become aware of any medications or dietary supplements that are being used by a resident and are not included in the assessment for medication management services, they will contact the RN." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access. This had the potential	01880		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

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01880	Continued From page 41 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) 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 a facility tour on September 25, 2023, at 11:05 a.m. licensed assisted living director in residency (LALDIR)-B opened a refrigerator near the nursing offices. The refrigerator did not have a lock on it and the door to the area was open and unlocked. Inside the refrigerator were food and beverages. The refrigerator also included R5's acidophilus capsules and R6's B-12 injection. The refrigerator was accessible to staff, residents, and visitors. LALDIR-B stated she did not think the refrigerator was a medication refrigerator so the medications should not have been in there. On September 25, 2023, at 3:30 p.m. director of nursing services (DNS)-D stated the refrigerator was not the medication refrigerator. R6's B-12 was in the refrigerator waiting for the nurses to destroy and the acidophilus was a medication the nurses set-up. DNS-D also stated the medications should not be stored in that refrigerator as it was not locked. The licensee's Storage of Medications policy dated March 3, 2022, identified "When secured storage of the medications is necessary, the RN will identify where the medications will be stored,	01880		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

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01880	Continued From page 42 how they will be secured or locked under proper temperature controls and who has access to the medications." "When clients are living in a congregate setting or similar senior housing setting, the RN will develop a procedure to secure medications when they are delivered to the building rather than delivered directly to the client in the client's living space." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	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 bearing the original prescription label, failed to ensure time sensitive medications were labeled with the date opened, and failed to remove expired medication from use for two of four medications carts (memory care and second floor), two of two medication cupboards (R6 and R16), and one of one medication refrigerator. 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	01890		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

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01890	Continued From page 43 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On September 25, 2023, at 3:55 p.m. during a medication administration observation, R6 with unlicensed personnel (ULP)-H, noted a Lantus insulin pen in the locked medication cupboard in R6's apartment. The Lantus pen had no pharmacy label attached. ULP-H stated there should have been a bag with a pharmacy label that the pen would have been stored in, but it was missing. On September 25, 2023, at 4:06 p.m. a review of three medication carts and one medication cupboard was completed with licensed practical nurse (LPN)-E with the following findings: -Memory care medication cart: - R11 had a Lantus insulin pen with no pharmacy label; - R9 had a Tresiba insulin pen with no open date; -Second floor assisted living medication cart - R13 had a tube of diclofenac gel with an expiration date of July 25, 2023. -A locked medication cupboard in R14's apartment had a Lantus insulin pen with no pharmacy label and no open date. LPN-E stated medications should be stored with a pharmacy label, should have an open date for time sensitive medications, and expired medications should be removed from the medication carts and destroyed per policy.	01890		

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01890	Continued From page 44 On September 25, 2023, at 4:40 p.m. director of nursing services (DNS)-D stated medications should have a pharmacy label, time sensitive mediations should have an open date, and expired medications should be removed from the medication carts. Medication refrigerator On September 28, 2023, at 3:30 p.m. a review of the medication refrigerator was completed with DNS-D and LPN-E and a Ziploc bag containing four Trulicity pens belonging to R6 with a label to discard after May 2, 2021, was observed. DNS-D stated she knew they should not be there, but they did not know how to destroy an insulin pen, so they were left in the refrigerator. The licensee's Storage of Medications policy dated March 3, 2022, identified "Until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy	01950		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

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01950	Continued From page 45 Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure urinary catheter (a tube which is inserted into the bladder to drain urine) irrigation was completed as ordered for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R3 was admitted on August 22, 2023, with	01950		

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BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

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01950	Continued From page 46 diagnoses including malignant neoplasm (cancer) of prostate, depression, congestive heart failure, and chronic kidney disease. R3's physician orders dated August 22, 2023, identified R3 had an indwelling urinary catheter and an order to irrigate bladder - flush Foley catheter TID (three times per day) using 60 cubic centimeters (cc) of normal saline. On September 27, 2023, at 9:47 a.m. director of nursing services (DNS)-D stated the licensed practical nurse (LPN) had contacted the physician and received a telephone order to do the irrigation twice a day Monday through Friday. The licensee did not have a signed order as the provider stated if he was at home he would do it on his own so the licensee did not need an order. R3's progress note on August 23, 2023, identified "8/22/23- Per urology nurse on 8/22/23- okay to irrigate Foley 2 x daily Mon - Fri r/t lo [sp] no licensed nurse after hours." R3's electronic medication administration record (MAR) dated September 1, 2023, through September 26, 2023, failed to identify the bladder irrigation treatment. R3's paper MAR, identified at the licensed nurse's MAR dated September 1, 2023, through September 26, 2023, identified "Irrigate bladder-flush Foley catheter TID using 60 cc normal saline twice dally Mon thru Fri. Twice A Day on Mon, Tue, Wed, Thu, Fri okay for this schedule per Urology nurse on 8/22/23" scheduled for 7:30 a.m. and 4:00 p.m. The MAR identified the following concerns: - Monday September 4, 2023, 7:30 a.m. and 4:00 p.m. nurse initials were circled and the back of	01950		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

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01950	Continued From page 47 the MAR indicated it was the holiday so the nurses were off; - Tuesday, September 5, 2023, 4:00 p.m. was blank; - Wednesday, September 6, 2023, 7:30 a.m. and 4:00 p.m. were blank; - Thursday, September 7, 2023, 4:00 p.m. was blank; - Monday, September 11, 2023, 4:00 p.m. was blank; - Wednesday, September 13, 2023, 7:30 a.m. and 4:00 p.m. were blank; - Friday, September 15, 2023, 4:00 p.m. nurse initials were circled and the back of the MAR indicated the nurse had to leave early, DNS-D completed later and completed on E-MAR, no corresponding documentation on the electronic MAR was identified; - Wednesday, September 20, 2023, 7:30 a.m. and 4:00 p.m. were blank; - Tuesday, September 26, 2023, at 4:00 p.m. the nurse initials were crossed out and a comment in the space under stated "signed" and illegible words. On September 28, 2023, registered nurse/licensed assisted living director (RN/LALD)-C stated she would expect the catheter irrigation to be completed as it was ordered. The licensee's Medication, Treatment, and Therapy Administration -Licensed and Unlicensed Personnel policy dated March 3, 2022, identified "Medication, treatment, or therapy will be administered as directed by the resident's Provider orders, the service plan and MAR." The licensee's Medication & Treatment Orders - Receiving, Implementing, Renewal and	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20291	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

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01950	Continued From page 48 Re-ordering policy dated August 1, 2021, identified: "a) All orders for medications and treatments must be dated and signed by the provider, and will be current and consistent with the nursing assessment. b) When new medication prescriptions are sent directly to the pharmacy by the provider or resident, the licensed nurse will request a copy of the prescription from the provider or from the pharmacy. c) When medication prescriptions are initiated by another health care provider, i.e. hospice or home care, the licensed nurse will request a copy of the prescription signed by a provider. d) Content of medication or treatment orders will contain: a. The date of issue b. Name and address of the resident c. Name and quantity of the drug prescribed d. Dosage, frequency, route and indication for use of medication e. Name and address of the prescriber and a telephone number where the prescriber can be reached f. The prescriber ' s manual or electronic signature e) Verbal orders received from a provider: a. Will be received by a licensed nurse or pharmacist b. Licensed nurse will receive and transcribe the order into the medical record. c. Licensed nurse will forward the written order to the provider for signature through mail, onsite visit or electronically". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01950		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

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01950	Continued From page 49 days	01950		
01970 SS=E	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written prescriber order for a treatment was obtained for three of three residents (R2, R3, and R16). 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: R2 R2 was admitted under the Assisted Living with Dementia Care license on August 1, 2021, with diagnoses of congestive heart failure, history of stroke, diabetes, depression, colostomy, and	01970		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

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01970	Continued From page 50 hypertension. On September 25, 2023, unlicensed personnel (ULP)-G and licensed practical nurse (LPN)-E were observed changing R2's colostomy device. R2's record lacked evidence of a physician's order of an ostomy device that staff were to change the device. R3 R3 was admitted on August 22, 2023, with diagnoses including malignant neoplasm (cancer) of prostate, depression, congestive heart failure, and chronic kidney disease. R3's physician orders dated August 22, 2023, identified R3 had an indwelling urinary catheter (a tube which is inserted into the bladder to drain urine) and an order to irrigate bladder - flush Foley catheter TID (three times per day) using 60 cubic centimeters (cc) of normal saline. On September 27, 2023, at 9:47 a.m. director of nursing services (DNS)-D stated the licensed practical nurse (LPN) had contacted the physician and received a telephone order to do the irrigation twice a day Monday through Friday. The licensee did not have a signed order as the provider stated if he was at home, he would do it on his own so the licensee did not need an order. R3's progress note on August 23, 2023, identified "8/22/23- Per urology nurse on 8/22/23- okay to irrigate Foley 2x daily Mon - Fri r/t lo [sp] no licensed nurse after hours." R3's electronic medication administration record (MAR) dated September 1, 2023, through September 26, 2023, failed to identify the bladder	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20291	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01970	Continued From page 51 irrigation treatment. R3's paper MAR, identified as the licensed nurse's MAR dated September 1, 2023, through September 26, 2023, identified "Irrigate bladder-flush Foley catheter TID using 60 cc normal saline twice dally Mon thru Fri. Twice A Day on Mon, Tue, Wed, Thu, Fri okay for this schedule per Urology nurse on 8/22/23" scheduled for 7:30 a.m. and 4:00 p.m. R16 R16 was admitted under the Assisted Living with Dementia Care license on May 9, 2022, with diagnoses of dementia, hypertension (high blood pressure), and anxiety. R16's electronic MAR for September 2023, indicated staff were completing wound care daily in the afternoon since September 2, 2023. R16's record lacked evidence of a physician's order for wound care to both legs due to open sores. On September 26, 2023, at 2:30 p.m. ULP-I completed R16's lower leg wound care by following the instructions on R16's MAR. On September 28, 2023, at 2:00 p.m. registered nurse (RN)-C stated R16's record did not include a physician's order for wound care prior to today. The licensee's Medication & Treatment Orders - Receiving, Implementing, Renewal and Re-ordering policy dated August 1, 2021, identified: "a) All orders for medications and treatments must be dated and signed by the provider, and will be current and consistent with the nursing	01970		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

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01970	Continued From page 52 assessment. b) When new medication prescriptions are sent directly to the pharmacy by the provider or resident, the licensed nurse will request a copy of the prescription from the provider or from the pharmacy. c) When medication prescriptions are initiated by another health care provider, i.e. hospice or home care, the licensed nurse will request a copy of the prescription signed by a provider. d) Content of medication or treatment orders will contain: a. The date of issue b. Name and address of the resident c. Name and quantity of the drug prescribed d. Dosage, frequency, route and indication for use of medication e. Name and address of the prescriber and a telephone number where the prescriber can be reached f. The prescriber's manual or electronic signature e) Verbal orders received from a provider: a. Will be received by a licensed nurse or pharmacist b. Licensed nurse will receive and transcribe the order into the medical record. c. Licensed nurse will forward the written order to the provider for signature through mail, onsite visit or electronically". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02240 SS=D	144G.90 Subdivision 1 Assisted living bill of rights; notification	02240		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

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02240	Continued From page 53 (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment	02240		

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02240	Continued From page 54 from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents and the written complaint notice was provided and a written acknowledgement was received for one of four residents (R15) with records reviewed. 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 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: R15's started receiving services from the licensee on December 14, 2018, to assist with activities of daily living (ADLs), medication administration, laundry, and housekeeping. On September 26, 2023, at 1:10 p.m. observed unlicensed professional (ULP)-I assisting R15 with ADLs. R15's records lacked evidence of written acknowledgement for receipt of the Minnesota Bill of Rights.	02240		

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	20291	A. BUILDING: _____ B. WING _____	09/29/2023

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02240	Continued From page 55 On September 28, 2023, at 2:03 p.m. licensed assisted living director in residency (LALDIR)-B No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02310 SS=H	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 provide care and services according to acceptable health care, medical, or nursing standards for two of three residents (R10 and R19) with side rails. This resulted in an immediate correction order on September 28, 2023, at 4:15 p.m. This practice resulted in a level three violation (a violation that harmed a client/resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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:	02310		

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02310	Continued From page 56 R10 R10 was admitted on November 18, 2021. On September 25, 2023, at 12:30 p.m. R10's twin bed was observed with an upside down 'U' shaped side rail slid between the two mattresses on the right side. R10's Side Rail/Grab/Mobility/Assist Bar Assessment form dated April 11, 2023, identified the side rail was used for independence in transfers, and the risk versus benefits were reviewed with the designated representative. R10's record did not include documentation of manufacturer instructions or that it had been checked for recalls. On September 28, 2023, at 3:50 p.m. registered nurse (RN)-C provided the manufacturer's instructions which indicated the device was recalled as an entrapment hazard. RN-C reviewed and confirmed R10's manufacturer's instructions identified the side rail was recalled on March 9, 2023. R19 R19 was admitted on July 20, 2023. R19's record lacked evidence of utilizing a siderail. On September 28, 2023, at 5:15 p.m. RN-C completed a review of the facility and stated R19 had a side rail, which they were not aware of. RN-C further stated they had not completed an assessment, education to the resident on the risks and benefits of side rail use, ensured it was installed and used according to manufacturer instructions, and had not checked to see if it was	02310		

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02310	Continued From page 57 recalled. On September 28, 2023, at 6:00 p.m. R19's double bed had an upside down 'U' shaped side rail that slid between the two mattresses on the right side of the bed. The licensee's undated, Assistive Bed Devices Policy indicated the nurse will fully complete the assistive bed device assessment and if the device is not approved the device will not be installed or removed if already installed. The Minnesota Department of Health's (MDH) Assisted Living Resources and Frequently Asked Questions (FAQs) webpage accessed September 26, 2023, at 9:06 a.m. and last updated August 7, 2023, read under the Consumer bed rails section, "The United States Consumer Product Safety Commission (CSPC) [LINK https://www.cpsc.gov/] works to save lives and ensure safety by reducing the unreasonable risk of injuries and deaths associated with consumer products, such as portable bed rails. The CSPC posts information on its website related to portable bed rail recalls. Licensees should review the CSPC website regularly for updates on recalled portable bed rails. The opportune time to do this would be with the 90-day assessment due to the requirement included in the uniform assessment tool for assessing assistive devices." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On September 29, 2023, at 10:44 a.m. the immediacy was removed based on observations by the surveyor and record reviews by the	02310		

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02310	Continued From page 58 evaluation supervisor; however, non-compliance remains at a scope and level of H.	02310		

Minnesota Department of Health
Food, Pools, Lodging
18 Woodlake Dr. SE
Rochester
507-206-2700

Type: Full
Date: *09/25/23*
Time: 10:34:51
Report: 8074231185

Food and Beverage Establishment Inspection Report

Location:
St Crispin Lvg Comm-The Villa
135 Pioneer Road
Red Wing, MN55066
Goodhue County, 25

Establishment Info:
ID #: 0038207
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513881234
ID #:

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

The following orders were issued during this inspection.

5-200C Plumbing: Maintenance, fixture location
5-205.11AB ***** Priority 2 *****
MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.
handwashing sink in front area used to wash grapes, use prep sink.
Comply By: 09/25/23

5-200C Plumbing: Maintenance, fixture location
5-205.13 ***** Priority 2 *****
MN Rule 4626.1120 Inspect, test and maintain water treatment and backflow prevention devices according to the manufacturer's instructions and as necessary to prevent device failure. The person in charge must maintain records of inspection and service of water treatment and backflow prevention devices.
last date on water filter 2017
Comply By: 09/25/23

Surface and Equipment Sanitizers

Hot Water: = at 172 Degrees Fahrenheit
Location: internal dish machine
Violation Issued: No

Acid: = 1875 at Degrees Fahrenheit
Location: sanitizer bucket
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *09/25/23*
Time: 10:34:51
Report: 8074231185
St Crispin Lvg Comm-The Villa

Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding
Temperature: 174 Degrees Fahrenheit - Location: chicken
Violation Issued: No

Process/Item: Hot Holding
Temperature: 196 Degrees Fahrenheit - Location: rice
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: watermelon
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: noodes, soup
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: tuna salad
Violation Issued: No

Process/Item: Cooking
Temperature: 189 Degrees Fahrenheit - Location: calzone
Violation Issued: No

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

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 8074231185 of 09/25/23.

Certified Food Protection Manager Sarah Peters

Certification Number: FM40285 Expires: 07/09/25

Signed: _____
Establishment Representative

Signed: _____
Andrea Kieffer

507-206-2721
andrea.kieffer@state.mn.us