Electronically Delivered

June 13, 2025

Licensee
Benedictine Living Community Anoka
910 Western Street
Anoka, MN 55303

RE: Project Number(s) SL24353016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 7, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24353	A. BUILDING: _____ B. WING _____	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY ANOKA	910 WESTERN STREET ANOKA, MN 55303

(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 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: SL24353016-0 On May 5, 2025, through May 7, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 75 resident(s); 66 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 5, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents receiving services under the assisted living with dementia license.	0 680		

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0 680	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EPP dated March 6, 2025, lacked evidence of quarterly review of the missing resident policy. On May 5, 2025, at 2:23 p.m., licensed assisted living director (LALD)-A stated, "We just did a missing person drill just a few months ago. I review the policies all the time, but I don't have evidence." The licensee's Missing Resident policy, dated 2024, did not address the need for quarterly policy review. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 775		

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0 775	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 6, 2025, at 10:25 a.m., the surveyor toured the facility with environmental services director (ESD)-D. During the facility tour, the surveyor observed the following: CARBON MONOXIDE ALARMS/ DETECTION - Carbon monoxide alarms were installed in the laundry rooms and basement mechanical room near gas fired equipment. During the facility tour interview, ESD-D stated the existing carbon monoxide alarms in the laundry rooms and mechanical room were not tied into the building fire alarm system. ESD-D stated the only carbon monoxide detectors connected to the fire alarm system for the building were installed in the parking garage. - Carbon monoxide alarms were not installed outside and within ten feet of all resident sleeping rooms. During the facility tour interview, ESD-D, stated carbon monoxide alarms were not installed in resident dwelling units. Carbon monoxide alarms and detection systems	0 775		

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0 775	Continued From page 6 in existing buildings are required to be installed in accordance with MSFC in Minnesota Rules Chapter 7511. SMOKE ALARM MAINTENANCE Round cover plates were installed on the ceiling in resident dwelling units. During the tour interview, ESD-D stated the cover plates were installed where hard wired smoke alarms had been removed when new wireless smoke alarms were installed two years ago. Hardwired smoke alarms are required to be maintained in accordance with MSFC in Minnesota Rules Chapter 7511. EMERGENCY LIGHTS The emergency lights did not work when tested by ESD-D in the second floor laundry room and in the lounge area near resident rooms 113 and 118. Emergency lights must be maintained in proper operating condition to illuminate escape routes in the event of a fire or power outage. During the tour interview, ESD-D verified the above listed emergency light observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 810 SS=E	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency;	0 810		

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0 810	Continued From page 7 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide required drills. 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:	0 810		

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0 810	Continued From page 8 On May 6, 2025, environmental services director (ESD)-D provided documents on the evacuation drills for the facility. Record review indicated the licensee failed to conduct evacuation drills for employees every other month evident by a review of fire drill reports lacking the required frequency. One fire drill report was provided for 2025, dated March 31, 2025. Seven fire drill reports were provided for 2024. Fire drills had been conducted in March, June, September, and October 2024. During an interview on May 6, 2025, at 1:45 p.m., ESD-D verified the evacuation drill frequency was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is	01060		

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01060	Continued From page 9 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 the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of an emergency relocation greater than four days for one of four residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01060		

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01060	Continued From page 10 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 was admitted to the licensee and began receiving assisted living services on February 18, 2025. R4's record included a progress note dated March 3, 2025, written by clinical nurse supervisor (CNS)-B, that indicated resident was hospitalized and would likely return to the licensee on March 4, 2025. R4's record lacked a written notice with the required statutory content provided to the resident, resident representative, or OOLTC of the emergency relocation. On May 6, 2025, at 4:16 p.m., clinical nurse supervisor (CNS)-B stated R4 was sent to the hospital on February 26, 2025, and returned to licensee on March 5, 2025. In addition, CNS-B stated staff are trained to complete an emergency relocation form right away when a resident goes to the hospital and places it on the CNS desk for review and to be sent to the Ombudsman if necessary. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		

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01760	Continued From page 11	01760		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication 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 transcribed as prescribed for one of three residents (R3). In addition, the licensee failed to ensure medications were readily available to administer as ordered for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24353	A. BUILDING: _____ B. WING _____	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY ANOKA	910 WESTERN STREET ANOKA, MN 55303

(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
01760	Continued From page 12 During the entrance conference on May 5, 2025, at 11:01 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. On May 6, 2025, at 8:45 a.m., surveyor observed ULP-G administer scheduled morning medications from pill organizer. R3 admitted to the licensee and began receiving assisted living services on September 9, 2024. R3's diagnoses included diabetes, hypertension (elevated blood pressure), heart failure, retention of urine, and atrial fibrillation (irregular heart rate). R3's signed Service Plan With Schedule dated April 22, 2025, indicated R3 received medication administration two times per day. R3's Medication Management Assessment dated April 22, 2025, indicated a licensed nurse manages all changes to prescriptions or orders and communications with the pharmacy or prescribers. R3's prescriber orders dated April 22, 2025, included the following medications: -apixaban (anticoagulant-blood thinner) 5 milligrams (mg) two times daily; -ascorbic acid (Vitamin C) 500 mg daily; -atorvastatin (cholesterol lowering) 10 mg daily; -dapagliflozin propanediol (diabetes and heart failure management) 10 mg daily; -furosemide (manage fluid retention in heart failure) 20 mg- take three tablets (60 mg) daily; -Metamucil (fiber supplement) Sugar-Free 3.4 gm/5.8 gm- mix one packet in liquid and drink two times daily; -metoprolol succinate (blood pressure	01760		

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01760	Continued From page 13 management) sustained release 25 mg- take 0.5 tablets (12.5 mg) daily; -nystatin (antifungal) powder applied to abdominal folds and groin two times daily; -potassium chloride (potassium supplement) 20 milliequivalent (mEq) daily; -spironolactone (potassium-sparing diuretic) 25 mg- take 0.5 tablets (12.5 mg) daily; and -tamsulosin (for improved urination) 0.4 mg daily. R3's Medication Administration Records (MAR) dated April 1, 2025, through May 1, 2025, and May 1, 2025, through May 6, 2025, indicated R3 did not receive ascorbic acid 500 mg or dapagliflozin propanediol 10 mg as prescribed. In addition, the MAR's indicated that R3 received empagliflozin 10 mg daily which was not included in the prescriber orders at time of hospital discharge on April 22, 2025. On May 6, 2025, at 3:45 p.m., licensed practical nurse (LPN)-F stated R3's ascorbic acid order was missed in error upon return from the hospital. In addition, LPN-F stated dapagliflozin propanediol was mistaken for R3's current Jardiance order because "the generic name for Jardiance is only one letter different." On May 6, 2025, at 3:47 p.m., clinical nurse supervisor (CNS)-B stated ascorbic acid was missed due to not being under the 'start taking these medicines' section of the hospital discharge orders. In addition, CNS-B stated missing the discontinuation of empagliflozin and starting dapagliflozin propanediol was a nursing error and will be treated as a medication error. The licensee's Medication & Treatment Orders-Receiving, Implementing, Renewal and Re-ordering policy, dated April 22, 2024,	01760		

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BENEDICTINE LIVING COMMUNITY ANOKA	910 WESTERN STREET ANOKA, MN 55303

(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
01760	Continued From page 14 indicated, "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." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01770		

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BENEDICTINE LIVING COMMUNITY ANOKA	910 WESTERN STREET ANOKA, MN 55303

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01770	Continued From page 15 On May 6, 2025, at 8:45 a.m., surveyor observed ULP-G administer scheduled morning medications from pill organizer. R3 admitted to the licensee and began receiving assisted living services on September 9, 2024. R3's diagnoses included diabetes, hypertension (elevated blood pressure), heart failure, retention of urine, and atrial fibrillation (irregular heart rate). R3's signed Service Plan With Schedule dated April 22, 2025, indicated R3 receives medication management services and the "licensed nurse (LN) managing medications either for med planner for staff to supervise or administer." R3's Medication Management Assessment dated April 22, 2025, indicated a licensed nurse manages all changes to prescriptions or orders and communications with the pharmacy or prescribers. R3's prescriber orders dated April 22, 2025, included the following medications: -apixaban (anticoagulant-blood thinner) 5 milligrams (mg) two times daily; -ascorbic acid (Vitamin C) 500 mg daily; -atorvastatin (cholesterol lowering) 10 mg daily; -dapagliflozin propanediol (diabetes and heart failure management) 10 mg daily; -furosemide (manage fluid retention in heart failure) 20 mg- take three tablets (60 mg) daily; -Metamucil (fiber supplement) Sugar-Free 3.4 gm/5.8 gm- mix one packet in liquid and drink two times daily; -metoprolol succinate (blood pressure management) sustained release 25 mg- take 0.5 tablets (12.5 mg) daily; -nystatin (antifungal) powder applied to abdominal	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01770	Continued From page 16 folds and groin two times daily; -potassium chloride (potassium supplement) 20 milliequivalent (mEq) daily; -spironolactone (potassium-sparing diuretic) 25 mg- take 0.5 tablets (12.5 mg) daily; and -tamsulosin (for improved urination) 0.4 mg daily. R3's medication set up documentation dated March 1, 2025, through March 31, 2025, indicated the following medications were set up by licensed practical nurse (LPN)-F through March 10, 2025: -tamsulosin 0.4 mg; -Jardiance (diabetes and heart failure management) 10 mg; -furosemide 20 mg- take three tablets (60 mg); -metoprolol succinate extended release (ER) 25 mg- take 0.5 tablets (12.5 mg); -potassium chloride 20 mEq; -spironolactone 25 mg- take 0.5 tablets (12.5 mg); -eliquis 5 mg; and -atorvastatin 10 mg. R3's record lacked medication set up documentation for April 2025 and May 2025. On May 6, 2025, at 3:45 p.m., LPN-F stated, "I thought we only had to document med set up if R3's wife was giving the meds and now [licensee staff] are giving them." In addition, LPN-F stated there is documentation that LPN-F acknowledged completion of 'Health related services' in Matrix (electronic health record software). On May 6, 2025, at 3:47 p.m., clinical nurse supervisor (CNS)-B stated medication set up requirements were misunderstood and are being re-started for R3.	01770		

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01770	Continued From page 17 The licensee's Medication Administration- Weekly Dosage Box Set Up policy, dated April 22, 2024, indicated "When the licensed nurse has completed setting up the medications, the nurse will document each individual medication that has been set up on the appropriate paper flowsheet." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were dated when opened or when expired for one of one resident (R7). In addition, the licensee failed to ensure expired medications were removed from one out of one (R7) resident's secure medication cabinet. 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	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01890	Continued From page 18 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: TIME SENSITIVE MEDICATION On May 5, 2025, at 7:50 a.m., the surveyor accompanied by unlicensed personnel (ULP)-D, observed R7's secured medication cabinet which contained the following: -Lantus (insulin) 100 milligrams (mg)/ milliliter (ml) pen with approximately 40 units (U) remaining; and -Lantus 100 mg/ml pen with approximately 100 U remaining. ULP-D acknowledged to surveyor there was no open date or expiration date written on either pen. EXPIRED MEDICATIONS On May 6, 2025, at 8:23 a.m., the surveyor accompanied by ULP-D, observed the contents of R7's secured medication cabinet and observed the following expired medications: -Mirtazapine (anti-depressant) 15 mg sublingual (SL) tablets with 11 tablets remaining. Provider order from July 17, 2024, read place one tab on the tongue at bedtime for dementia. The medication expired April 2025. -Mirtazapine 15 mg SL tablets with four tablets remaining. Provider order from July 17, 2024, read place one tab on the tongue at bedtime for dementia. The medication expired April 2025. -Pain-relief patches over the counter (OTC) with 27 patches remaining. Provider order from July 17, 2024, read apply patch to most painful area in the morning and remove at bedtime. The medicated patches expired November 2024.	01890		

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01890	Continued From page 19 R7's electronic medication administration record (EMAR) dated April 1, 2025, through April 30, 2025, indicated R7 received Mirtazapine 15 mg daily as ordered. In addition, R7's April 2025 EMAR indicated R7 requested a pain patch be applied only on April 5, 2025. R7's EMAR dated May 1, 2025, through May 7, 2025, indicated R7 received Mirtazapine 15 mg daily as ordered. In addition, R7's May 2025 EMAR indicated R7 requested a pain patch be applied only on May 7, 2025. On May 6, 2025, at 7:50 a.m., ULP-D stated the Lantus supply in R7's cabinet was unable to be utilized due to lacking documentation of the date it was opened or the date it expires. ULP-D called nursing staff on site and requested a new supply be brought to R7's room for administration. On May 6, 2025, at 8:33 a.m., ULP-D stated nursing completes medication supply audits for expiration and supplies needing to be ordered. On May 7, 2025, at 8:10 a.m., clinical nurse supervisor (CNS)-B stated nursing completes weekly medication supply audits to look for expiration dates, refills needed, and complete medication set-ups. In addition, CNS-B stated not removing the expired medication from R7's cabinet was a nursing error. The licensee's Medication Disposal and Med Safe policy, dated April 22, 2024, indicated "Expired medications managed by assisted living will disposed of according to the accepted practices of the Minnesota board of Pharmacy and the labels from the containers will be destroyed. Upon disposition, the facility must	01890		

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01890	Continued From page 20 document in the resident's record the disposition of the expired medication including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition. " No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01910		

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01910	Continued From page 21 licensee failed to provide documentation in the resident's record regarding the disposition of medication to including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for two of two discharged residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee and began receiving services on March 7, 2020. R1 discharged to another facility on February 13, 2025. R1's discharge summary dated February 13, 2025, indicated R1 received medication management services. R1's medication disposition record lacked the following content: -prescription numbers as applicable; and -whom the medications were given to. R2 R2 was admitted to the licensee and began receiving services on December 27, 2023.	01910		

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01910	Continued From page 22 R2 discharged to another facility on April 10, 2025. R2's discharge summary dated April 10, 2025, indicated R2 received medication management services. R2's medication disposition record lacked evidence of whom the medications were given to. On May 6, 2025, at 3:50 p.m., clinical nurse supervisor (CNS)-B stated including prescription numbers on medication disposition documentation has not been 'typical' practice for any discharge. In addition, CNS-B stated CNS-B was unaware the inclusion of the prescription number on a medication disposition was a requirement. The licensee's Medication Disposal and Med Safe policy, dated April 22, 2024, indicated, "Current unused medications managed by the assisted living will be returned to the pharmacy for credit, or given to the resident or the resident's representative, when the resident's medications are no longer managed by the facility or the medication has been discontinued by the prescriber. Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01910		

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01910	Continued From page 23 days	01910		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Benedictine Living Community A
910 Western Street
Anoka, MN 55303
Anoka County
Parcel:

Phone:

License Info

License: HFID 24353

Risk:
License:
Expires on:
CFPM: ANTHONY T. JARA
CFPM #: 44904; Exp: 1/23/2027

Inspection Info

Report Number: F1029251002
Inspection Type: Full - Single
Date: 5/5/2025 Time: 10:55:38 AM
Duration: 90 minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 3
Delivery: Emailed

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-307.11 *Priority Level: Priority 3 CFP#: 39*
MN Rule 4626.0337 Protect food from miscellaneous sources of contamination.
COMMENT: AREAS OF CEILING W/ CRACKING AND CHIPPING PAINT. REP INSTRUCTED TO NOT STORE FOODS OR THINGS THAT INTERACT W/ FOODS UNDER AREAS WHERE PAINT IS FLECKING OFF.
Comply By: 5/5/2025 Originally Issued On: 5/5/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: MIN/MAX THERMOMETER NOT WORKING. REP INSTRUCTED TO MAKE OPERATIONAL AND USE TO VERIFY DISHWASHER HIGH TEMPS TO AT LEAST 160F.
Comply By: 5/5/2025 Originally Issued On: 5/5/2025

New Order: 6-100 Physical Facility Construction Materials
6-101.11A1 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.
COMMENT: CEILING PAINTED W/ PAINT CHIPPING OFF IN AREAS. SECTIONS OF WALLS ONLY PAINTED. OTHER SECTIONS COVERED IN FRP OR SUBWAY TILE. REP INSTRUCTED TO HAVE WALLS AND CEILING COVERED WITH SMOOTH, DURABLE, NON-ABSORBENT, EASILY CLEANABLE, AND INERT MATERIAL SUCH AS PVC, FRP, STAINLESS STEEL, ETC. ENSURE FLOOR SLOPES TO DRAINS TO PREVENT WATER FROM POOLING.
Comply By: 9/30/2025 Originally Issued On: 5/5/2025

New Order: 6-200 Physical Facility Design and Construction
6-201.13A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1345A Properly cove and seal the wall/floor junctures to no larger than 1/32 inch (1 millimeter).
COMMENT: QUARRY TILE INTEGRAL BASE COVE BROKEN OR MISSING OR REPLACED WITH UNAPPROVED VINYL COVE IN AREAS. REP INSTRUCTED TO PROVIDE INTEGRAL BASE COVE THROUGHOUT FOOD SERVICE AREA. MATERIAL SHOULD BE SMOOTH, DURABLE, EASILY CLEANABLE, AND NON-ABSORBENT SUCH AS TILE, COMMERCIAL EPOXY, STAINLESS STEEL, ETC. NEWLY INSTALLED COVE SHOULD EXTEND UP THE WALL AT LEAST 4".
Comply By: 9/30/2025 Originally Issued On: 5/5/2025

Food & Beverage General Comment

FOOD AND BEVERAGE INSPECTION AS PART OF HRD SURVEY. ALL IDENTIFIED ISSUES COMMUNICATED TO

ESTABLISHMENT REPRESENTATIVE. EMPLOYEE ILLNESS LOGGING, SANITARY PRACTICES, TEMPERATURES, AND PROTECTION FROM CONTAMINATION COVERED.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1029251002 from 5/5/2025

Trevor McCliment

TONY JARA
CULINARY DIRECTOR

Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

Benedictine Living Community A
Anoka
County/Group: Anoka County

Inspection Info

Report Number: F1029251002
Inspection Type: Full
Date: 5/5/2025
Time: 10:55:38 AM

Food Temperature: Product/Item/Unit: BEEF MEATBALL **; Temperature Process:** Cooking
Location: Oven at 195 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHICKEN SALAD**; Temperature Process:** Cooling
Location: Walk-in Cooler at 62 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHOPPED WATERMELON**; Temperature Process:** Cooling
Location: Walk-in Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: COOKED RICE**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 36 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: SLICED TOMATOES**; Temperature Process:** Cold-Holding
Location: UNDER GRIDDLE COOLER at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHOPPED ICEBURG LETTUCE**; Temperature Process:** Cold-Holding
Location: UNDER GRIDDLE COOLER at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: RAW BEEF BURGER PATTY**; Temperature Process:** Cold-Holding
Location: UNDER GRIDDLE COOLER at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: POTATO SOUP**; Temperature Process:** Hot-Holding
Location: Steam Table at 165 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: COTTAGE CHEESE**; Temperature Process:** Cold-Holding
Location: SERVER COOLER 2-DOOR UPRIGHT at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** SLICED TURKEY**; Temperature Process:** Cold-Holding
Location: KITCHEN 1-DOOR UPRIGHT at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** SLICED HAM**; Temperature Process:** Cold-Holding
Location: KITCHEN 1-DOOR UPRIGHT at 40 Degrees F.
Comment:
Violation Issued?: No

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Sanitizer Observations/Recordings

Establishment Info

Benedictine Living Community A
Anoka
County/Group: Anoka County

Inspection Info

Report Number: F1029251002
Inspection Type: Full
Date: 5/5/2025
Time: 10:55:38 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** High Temp Dishwasher
Location: Dishwashing Area **Greater Than** 160 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Lactic Acid**; Sanitizing Process:** Dispenser
Location: Mop Sink Area **Equal To** 1875 PPM
Comment: 1875 PPM L.ACID
Violation Issued?: No

Sanitizing Chemical: **Product:** Lactic Acid**; Sanitizing Process:** Wiping Cloth Bucket
Location: Dishwashing Area **Greater Than** 705 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Lactic Acid**; Sanitizing Process:** Wiping Cloth Bucket
Location: Server Station **Greater Than** 705 PPM
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1029251002

Food Establishment Inspection Report

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

No. of Risk Factor/Intervention/Violations	0	Date: 5/5/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 10:55:38 AM
Score (optional)		Dur: 90 min

Establishment:	Address:	City/State:	Zip:	Phone:
Benedictine Living Community A	910 Western Street	Anoka, MN	55303	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 24353		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	IN	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	IN	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	IN	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
		Safe Food and Water		
30	IN	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39	X	Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) Trevor McClime

Follow-up: Follow-up Date: