Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 18, 2025

Administrator
Benedictine Care Community
201 9th Street West
Ada, MN 56510

RE: CCN: 245502
Cycle Start Date: April 9, 2025

Dear Administrator:

On April 9, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 9, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 9, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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April 18, 2025

Administrator
Benedictine Care Community
201 9th Street West
Ada, MN 56510

Re: State Nursing Home Licensing Orders
Event ID: QK9Z11

Dear Administrator:

The above facility was surveyed on April 7, 2025 through April 9, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	C 04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(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) COMPLETION DATE
E 000	Initial Comments On 4/7/25 to 4/9/25, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/7/25 to 4/9/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued: H55021322C (MN00101107), H55021304C (MN00103924), H55021305C (MN00110012). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/28/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nebulizer medications were administered safely for 1 of 1 resident (R19) who was observed to self administer a nebulizer and had not been assessed as safe to self administer medications. Findings include: R19's quarterly Minimum Data Set (MDS) dated 3/7/25, indicated R19 had severe cognitive impairment and had diagnosis which included Alzheimer's, diabetes mellitus (DM), and hypertension (elevated blood pressure). Indicated R19 required extensive assistance with bed mobility, transfers, toileting and personal hygiene. Review of R19's electronic health record (EHR) revealed a self administration of medications (SAM) assessment had not been completed and R19 did not have an order for self administration of medications. R19's Physician Order report dated 1/23/25, and signed 3/25/25, directed staff to administer	F 554	Based on observation, interview and document review, the facility failed to ensure nebulizer medications were administered safely for 1 of 1 resident (R19) who was observed to self administer a nebulizer and had not been assessed as safe to self administer medications. Affected Resident R19 on spot re-education with LPN completed by DON Potential Affected Residents include all residents with a nebulizer order. Nursing re-education regarding nebulizers and self-administration of medication policy. 4/09/25 Placed in communication book on each unit. Nurse LPN-A received on spot re-education. Given a coaching disciplinary and review of the self-administration of medication policy. Self-administration of medication was	5/9/25

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F 554	Continued From page 2 Ipratropium-albuterol inhalation solution DuoNeb (medication used to relax the muscles in the airways and increase air flow to the lungs) four times daily (QID) and every six hours as needed for wheezing, and cough. R19's care plan dated 11/19/24, directed staff to administer all medications as ordered. During a continuous observation on 4/7/25 at 4:30 p.m., licensed practical nurse (LPN)-A poured nebulizer solution in a nebulizer mask, placed the neb mask on R19's face and walked out of the room back to the medication cart. At 4:32 p.m., R19 removed the nebulizer mask with the medication mist still coming from the mask from her face and placed it on her bed. R19 proceeded to grab her walker which was next to the bed, walked into the hallway and sat in a stationary chair. At 4:41 LPN-walked into R19's room, removed the neb mask from the bed and placed it on the neb machine. During an interview on 4/7/25 at 4:43 p.m., LPN-A verified she had placed the nebulizer treatment on R19 and exited the room. LPN-A stated she was unsure if a SAM assessment had been completed for R19. LPN-A stated she was unsure if R19 was safe to administer her own nebulizer or if staff were to stay with R19 while she did her nebulizer. During an interview on 4/7/25 at 4:49 p.m., registered nurse (RN)-A confirmed R19 did not have a SAM assessment for nebulizer treatments. RN-A stated her expectation was nursing staff would have stayed in the room with R19 while she received the nebulizer treatments to ensure R19 received the nebulizer treatment	F 554	reviewed and remains current. Nurse LPN-A received on spot re-education. Given a coaching disciplinary and review of the self-administration of medication policy Add verbiage to current residents who receive nebulizers that do not have a self -administration of medication order that states, do not leave resident unattended when administering nebulizer medication Audit all residents current nebulizer orders that do not have self-administration of medication and ensure verbiage to be included in transcribing order, do not leave resident unattended when administering nebulizer medication. Audit all new residents with nebulizer orders that do not have a self-administration of medication and ensure verbiage to be included in transcribing order, do not leave resident unattended when administering nebulizer medication. Random audit of resident with nebulizer that does not have order to self-administer medication 1x a week x one month. Results of monitoring shall be reported at the facility QAA meeting with ongoing frequency and duration to be determined through analysis and review of results.	

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F 554	Continued From page 3 appropriately. During an interview on 4/9/25 at 12:15 p.m., director of nursing (DON) verified R19 did not have a SAM assessment. DON indicated if the resident did not have a SAM assessment or physician's orders, staff were expected to remain with the resident during the entire nebulizer administration. Review of a facility policy titled Self-Administration of Medications revised 8/31/23, identified nurses would assess each resident's mental and physical abilities to determine if self-administration of medications was clinically appropriate and safe. Identified if it was determined to not be safe for the resident to self-administer medications, the nurses would administer the medications.	F 554		
F 585 SS=F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F 585		5/9/25

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F 585	Continued From page 4 §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and	F 585		

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F 585	Continued From page 5 coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure grievance	F 585	Based on observation, interview, and document review, the facility failed to	

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F 585	Continued From page 6 forms and procedures were posted in prominent locations throughout the facility for residents and resident representatives to file grievances, and anonymously if desired for 5 of 5 residents (R1, R25, R35, R36 and R37) reviewed for grievances. This deficient practice had the potential to affect all 39 residents residing in the facility. Findings include: On 4/8/25 at 11:00 p.m., a resident council meeting was held with five residents: R1, R25, R35, R36, and R37. During the resident council meeting, all five residents indicated they were unaware of how to file a grievance form. During an observation on 4/8/25 at 11:35 p.m., the surveyor could not locate grievance forms throughout the facility. During an interview on 4/8/25 at 11:43 a.m., social worker (SW) stated grievance forms were located behind the nurses' station. SW stated if a resident wanted to file a grievance, they would have to go to the staff to ask for a form. During an interview on 4/8/25 at 11:57 a.m., administrator confirmed the grievance forms were behind the nurses' station and was unable to locate grievances that were posted in prominent locations for the residents or resident representatives to file grievances anonymously. The facility posting titled Grievance Procedure, undated, identified if concern or suggestions, the facility encouraged them to notify the nurse in charge. If the matter could not be resolved by the charge nurse, they could contact the director of	F 585	ensure grievance forms and procedures were posted in prominent locations throughout the facility for residents and resident representatives to file grievances, and anonymously if desired for 5 of 5 residents (R1, R25, R35, R36 and R37) reviewed for grievances. This deficient practice had the potential to affect all 39 residents residing in the facility. 4/8/25 Residents were informed of process and where the concerns, grievance forms are located Potential to affect all residents. Residents were informed of location of forms during resident council on 4/8/25 and notes of resident council meeting were provided to all residents with this information on the same day. Communication to resident contacts was done to provide them with notice of where the anonymous grievance forms are now located. Staff re-educated of grievance process and location of forms on 4/10/2025. Admission packet that is provided to each resident upon admission includes grievance notice, right to file grievance information. Social worker will inform new residents going forward where to find anonymous grievance forms and how to use them. Grievance forms are in locations that are easily accessible to all residents/family members.	

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F 585	Continued From page 7 nursing, director of programs and operations, or the grievance officer, whose names, phone numbers and e-mails were listed. The procedure identified grievances may be filed orally or in written format. Review of a facility policy titled Concerns, Grievances revised 9/17/2019 identified residents and resident representatives were informed of rights and concern forms are available to residents/families. Identified concern forms were readily available for use by families and residents.	F 585	Weekly random audits asking residents and resident representatives x one month if they are aware of our grievance procedure and where they can find the grievance form? Results of monitoring shall be reported at the facility QAA meeting with ongoing frequency and duration to be determined through analysis and review of results. DON, Administrator, or other associate as assigned will oversee the process.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with personal hygiene for 1 of 1 residents (R12) reviewed for activities of daily living (ADL)'s. Findings include: R12's quarterly Minimum Data Set (MDS) dated 2/21/25, identified R12 had severe cognitive impairment and had diagnoses which included dementia, diabetes mellitus (DM), and hypertension (elevated blood pressure). Identified R12 required one person physical assist from staff with personal hygiene. R12's current care plan revised 3/26/25, indicated R7 had deficits with ADL's related to dementia.	F 677	Based on observation, interview and document review, the facility failed to provide assistance with personal hygiene for 1 of 1 residents (R12) reviewed for activities of daily living (ADL)'s. 4/8/25 staff shaved R12 facial hair All residents have the potential to be affected by this. 4/9/25 staff trimmed, shaved and plucked facial hair with morning cares of all residents. Review of ADL policy was reviewed and remains current.	5/9/25

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	245502	A. BUILDING _____ B. WING _____	C 04/09/2025

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F 677	Continued From page 8 Indicated R12 required staff assistance with personal hygiene and had a goal to be clean and well groomed. R12's annual comprehensive Care Area Assessment (CAA) dated 5/25/24, identified R12 required assistance with ADL's. Identified R7 had an activity intolerance related to weakness, physical limitations and dementia. R12's care sheet undated, identified R12 required staff assistance with grooming. During an observation on 4/7/25 at 1:30 p.m., R12 was seated in a stationary chair in her room and had several half inch long gray facial hairs on her chin, above her upper lip, and around her mouth During an interview on 4/7/25 at 2:07 p.m., family member (FM)-A stated R12 preferred to be shaved when facial hair was visible. During an observation on 4/8/25 at 9:28 am., R12 seated in a stationary chair in her room and continued to have several half inch long gray facial hairs on her chin, above her upper lip, and around her mouth. During a joint interview on 4/8/25 at 9:36 a.m., nursing assistant (NA)-A and registered nurse (RN)-A verified R12 has several long gray facial hairs. NA-A stated R12 required staff assistance to shave facial hair. NA-A stated she had not assisted R12 with shaving recently and was unsure the last time R12 had been shaved. RN-A stated her expectation was that R12 would have been shaved as soon as facial hair was present.	F 677	Re-education of ADL policy and system provided to all staff on 4/10/25. All resident care plans have been reviewed and are accurate. ADL policy is reviewed upon hire with all new staff. Random facial hair audits 2x a week for one month. Results of monitoring shall be reported at the facility QAA meeting with ongoing frequency and duration to be determined through analysis and review of results. DON or other associate as assigned will be responsible for monitoring audits and any further education needed.	

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F 677	Continued From page 9 During an interview on 4/9/25 at 12:17 p.m., director of nursing (DON) indicated R12 required staff assistance with shaving. DON stated her expectation was R12 would have been shaved when facial hair was present. A Facility policy titled Activities of Daily Living (ADL's) dated 6/21, indicated residents unable to carry out ADL's independently would have received services necessary to maintain good personal hygiene in accordance with all resident care plans.	F 677		
F 851 SS=F	. Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who,	F 851		5/9/25

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F 851	Continued From page 10 through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by	F 851		

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F 851	Continued From page 11 CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit complete and accurate direct care staffing information, including information for agency and contracted staff, based on payroll and other verifiable and auditable data, during 1 of 1 quarters reviewed (Quarter 1), to the Centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS. This deficient practice had the potential to affect all 39 residents residing in the facility. Findings include: Review of the Payroll Based Journal Report (PBJ) Casper Report 1705 D identified excessively low weekend staffing. Review of agency staff timecards from the first quarter verified agency staff were not punching in, therefore agency staff hours were not being submitted to CMS. During an interview on 4/8/25 at 2:41 p.m., corporate submitter (CS) verified she was the one that submitted the PBJ reports for the facility. CS stated she was unaware the facility was triggering for excessive low weekend staffing on the PBJ report. (CS) stated when the agency staff failed to punch in for their shift, they were not included in the PBJ submission that she submitted to CMS for the facility. CS stated the facility was responsible to ensure the agency staff were	F 851	Based on interview and document review, the facility failed to submit complete and accurate direct care staffing information, including information for agency and contracted staff, based on payroll and other verifiable and auditable data, during 1 of 1 quarters reviewed (Quarter 1), to the Centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS. This deficient practice had the potential to affect all 39 residents residing in the facility. Potential to affect all residents. Education with weekend nurse managers done on 4/10/2025 to ensure agency staff are punching in, including on weekends. Agencies that are utilized at our site were educated on 4/10/2025 and are reminding their staff to punch in, including on weekends when working at this facility. Re-education provided to all staff and scheduler on 4/10/2025. Scheduler will meet with each new agency staff individually to ensure they are trained to use the time clock and the expectation is given to punch in and out for every shift using the time clock at the facility.	

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F 851	Continued From page 12 punching in for their shifts. During an interview on 4/8/25, at 4:58 p.m., administrator confirmed the above findings and verified agency staff had not been punching in for their shift during the first quarter. Administrator stated they would need to put a process into place to ensure that agency staff are punching in for their shift so that they are included in the PBJ submissions. Review of a facility policy titled Electronic Staffing Data Submission dated 2018, identified direct care -staffing information per day (including agency and contracted staff) was submitted to the CMS payroll-based journal (PBJ) system on the schedule specified by CMS, but no less than once per quarter.	F 851	Scheduler and director of nursing to meet weekly to audit hours entered and invoices from agencies to ensure complete and accurate data. Results of monitoring shall be reported at the facility QAA meeting with ongoing frequency and duration to be determined through analysis and review of results. DON or other associate as assigned will oversee audits and will provide additional education as needed.	

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/7/25 to 4/9/25, a licensure survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed with no deficiency issued. H55021322C (MN00101107), H55021304C (MN00103924), H55021305C (MN00110012). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility	2 000		

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with personal hygiene for 1 of 1 residents (R12) reviewed for activities of daily living (ADL)'s. Findings include: R12's quarterly Minimum Data Set (MDS) dated 2/21/25, identified R12 had severe cognitive impairment and had diagnoses which included dementia, diabetes mellitus (DM), and hypertension (elevated blood pressure). Identified R12 required one person physical assist from staff with personal hygiene. R12's current care plan revised 3/26/25, indicated	2 920	corrected	5/9/25

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2 920	Continued From page 3 R7 had deficits with ADL's related to dementia. Indicated R12 required staff assistance with personal hygiene and had a goal to be clean and well groomed. R12's annual comprehensive Care Area Assessment (CAA) dated 5/25/24, identified R12 required assistance with ADL's. Identified R7 had an activity intolerance related to weakness, physical limitations and dementia. R12's care sheet undated, identified R12 required staff assistance with grooming. During an observation on 4/7/25 at 1:30 p.m., R12 was seated in a stationary chair in her room and had several half inch long gray facial hairs on her chin, above her upper lip, and around her mouth During an interview on 4/7/25 at 2:07 p.m., family member (FM)-A stated R12 preferred to be shaved when facial hair was visible. During an observation on 4/8/25 at 9:28 am., R12 seated in a stationary chair in her room and continued to have several half inch long gray facial hairs on her chin, above her upper lip, and around her mouth. During a joint interview on 4/8/25 at 9:36 a.m., nursing assistant (NA)-A and registered nurse (RN)-A verified R12 has several long gray facial hairs. NA-A stated R12 required staff assistance to shave facial hair. NA-A stated she had not assisted R12 with shaving recently and was unsure the last time R12 had been shaved. RN-A stated her expectation was that R12 would have been shaved as soon as facial hair was present.	2 920		

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2 920	Continued From page 4 During an interview on 4/9/25 at 12:17 p.m., director of nursing (DON) indicated R12 required staff assistance with shaving. DON stated her expectation was R12 would have been shaved when facial hair was present. A Facility policy titled Activities of Daily Living (ADL's) dated 6/21, indicated residents unable to carry out ADL's independently would have received services necessary to maintain good personal hygiene in accordance with all resident care plans. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to activities of daily living. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing assistance with activities of daily living. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nebulizer	21565	corrected	5/9/25

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21565	Continued From page 5 medications were administered safely for 1 of 1 resident (R19) who was observed to self administer a nebulizer and had not been assessed as safe to self administer medications. Findings include: R19's quarterly Minimum Data Set (MDS) dated 3/7/25, indicated R19 had severe cognitive impairment and had diagnosis which included Alzheimer's, diabetes mellitus (DM), and hypertension (elevated blood pressure). Indicated R19 required extensive assistance with bed mobility, transfers, toileting and personal hygiene. Review of R19's electronic health record (EHR) revealed a self administration of medications (SAM) assessment had not been completed and R19 did not have an order for self administration of medications. R19's Physician Order report dated 1/23/25, and signed 3/25/25, directed staff to administer Ipratropium-albuterol inhalation solution DuoNeb (medication used to relax the muscles in the airways and increase air flow to the lungs) four times daily (QID) and every six hours as needed for wheezing, and cough. R19's care plan dated 11/19/24, directed staff to administer all medications as ordered. During a continuous observation on 4/7/25 at 4:30 p.m., licensed practical nurse (LPN)-A poured nebulizer solution in a nebulizer mask, placed the neb mask on R19's face and walked out of the room back to the medication cart. At 4:32 p.m., R19 removed the nebulizer mask with the medication mist still coming from the mask from her face and placed it on her bed. R19	21565		

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21565	Continued From page 6 proceeded to grab her walker which was next to the bed, walked into the hallway and sat in a stationary chair. At 4:41 LPN-walked into R19's room, removed the neb mask from the bed and placed it on the neb machine. During an interview on 4/7/25 at 4:43 p.m., LPN-A verified she had placed the nebulizer treatment on R19 and exited the room. LPN-A stated she was unsure if a SAM assessment had been completed for R19. LPN-A stated she was unsure if R19 was safe to administer her own nebulizer or if staff were to stay with R19 while she did her nebulizer. During an interview on 4/7/25 at 4:49 p.m., registered nurse (RN)-A confirmed R19 did not have a SAM assessment for nebulizer treatments. RN-A stated her expectation was nursing staff would have stayed in the room with R19 while she received the nebulizer treatments to ensure R19 received the nebulizer treatment appropriately. During an interview on 4/9/25 at 12:15 p.m., director of nursing (DON) verified R19 did not have a SAM assessment. DON indicated if the resident did not have a SAM assessment or physician's orders, staff were expected to remain with the resident during the entire nebulizer administration. Review of a facility policy titled Self-Administration of Medications revised 8/31/23, identified nurses would assess each resident's mental and physical abilities to determine if self-administration of medications was clinically appropriate and safe. Identified if it was determined to not be safe for the resident to self-administer medications, the nurses would	21565		

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21565	Continued From page 7 administer the medications. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review with staff current policies to ensure residents who were self administering medication had been assessed and were appropriate to administer their own medication, along with a physician's order for administration. The DON could audit resident to ensure assessment, and physician orders for self administration were in place. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every	21880		5/9/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00413	A. BUILDING: _____ B. WING _____	C 04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(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
21880	Continued From page 8 facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure grievance forms and procedures were posted in prominent locations throughout the facility for residents and resident representatives to file grievances, and anonymously if desired for 5 of 5 residents (R1, R25, R35, R36 and R37) reviewed for grievances. This deficient practice had the potential to affect all 39 residents residing in the facility. Findings include: On 4/8/25 at 11:00 p.m., a resident council meeting was held with five residents: R1, R25,	21880	corrected	

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	00413	A. BUILDING: _____ B. WING _____	C 04/09/2025

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21880	Continued From page 9 R35, R36, and R37. During the resident council meeting, all five residents indicated they were unaware of how to file a grievance form. During an observation on 4/8/25 at 11:35 p.m., the surveyor could not locate grievance forms throughout the facility. During an interview on 4/8/25 at 11:43 a.m., social worker (SW) stated grievance forms were located behind the nurses' station. SW stated if a resident wanted to file a grievance, they would have to go to the staff to ask for a form. During an interview on 4/8/25 at 11:57 a.m., administrator confirmed the grievance forms were behind the nurses' station and was unable to locate grievances that were posted in prominent locations for the residents or resident representatives to file grievances anonymously. The facility posting titled Grievance Procedure, undated, identified if concern or suggestions, the facility encouraged them to notify the nurse in charge. If the matter could not be resolved by the charge nurse, they could contact the director of nursing, director of programs and operations, or the grievance officer, whose names, phone numbers and e-mails were listed. The procedure identified grievances may be filed orally or in written format. Review of a facility policy titled Concerns, Grievances revised 9/17/2019 identified residents and resident representatives were informed of rights and concern forms are available to residents/families. Identified concern forms were readily available for use by families and residents. SUGGESTED METHOD FOR CORRECTION:	21880		

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	00413	A. BUILDING: _____ B. WING _____	C 04/09/2025

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21880	Continued From page 10 The director of nursing (DON) or designee could review and/or revise policies and procedures to ensure resident's have access to file a grievance anonymously. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**04/07/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE CARE COMMUNITY	**201 9TH STREET WEST ADA, MN 56510**

(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) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/07/2025. At the time of this survey, Benedictine Care Community - Ada was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/28/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**04/07/2025**

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BENEDICTINE CARE COMMUNITY	**201 9TH STREET WEST** **ADA, MN 56510**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Benedictine Care Community is a 1-story building without a basement. The building was constructed in 2000 and was determined to be of Type I(222) construction. The building is separated from the Hospital Building with a 2-hour fire barrier and the nursing home is divided into 3 smoke compartments with 1-hour fire barriers. The building is fully sprinkler protected with quick response sprinklers and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is	K 000		

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	245502	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**04/07/2025**

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BENEDICTINE CARE COMMUNITY	**201 9TH STREET WEST ADA, MN 56510**

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K 000	Continued From page 2 monitored for automatic fire department notification. Because the main facility and the chapel addition are both conforming contrstuction types for a 1-story building, the entire facility will be surveyed as one Type V(111) building. The facility has a capacity of 46 beds and had a census of 39 at the time of the survey.	K 000		
K 331 SS=D	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provided interior finish materials that meets the NFPA Life Safety Code 101 2012 edition sections 19.3.3.1, 19.3.3.2, and 10.2.3. This deficient condition could have a isolated impact on the residents within the facility.	K 331	Based on observation and staff interview, the facility failed to provided interior finish materials that meets the NFPA Life Safety Code 101 2012 edition sections 19.3.3.1, 19.3.3.2, and 10.2.3. This deficient condition could have a isolated impact on the residents within the facility.	5/9/25

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	245502	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**04/07/2025**

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K 331	Continued From page 3 Findings include: On 04/07/2025 between 1:30 PM. to 3:00 PM., it was observed that the facility has painted shiplap in the corridors of the reception area. At the time of the inspection it could not be verified that it was treated with a fire retardant finish. An interview with the Maintenance Manager verified this deficient finding at the time of discovery.	K 331	Fire retardant clear coat purchased on 4/23/2025 and will be painted on interior walls; to be completed by facility staff.	