DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 8, 2026

Administrator
Benedictine Living Community Mother of Mercy
230 Church Avenue, Box 676
Albany, MN 56307

RE: CCN: 245339
Cycle Start Date: June 4, 2026

Dear Administrator:

On July 1, 2026, the Minnesota Departments of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 29, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 4, 2026, did not go into effect. (42 CFR 488.417 (b))

In our letter of June 26, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 4, 2026. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 15, 2026

Administrator

Benedictine Living Community Mother of Mercy

230 CHURCH AVENUE, BOX 676

ALBANY, MN 56307

RE: CCN: 245339

Cycle Start Date: June 4, 2026

Dear Administrator:

On June 4, 2026, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted immediate jeopardy (Level J), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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)).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 30, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 30, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 30, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your

obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

- Civil money penalty. (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Benedictine Living Community Mother of Mercy is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 4, 2026. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N

P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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.

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 4, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

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.

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.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899

Office: 651-201-4384 | Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Living Community Mother of Mercy	**230 CHURCH AVENUE, BOX 676 , ALBANY, Minnesota, 56307**

(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
F0000	INITIAL COMMENTS On 6/3/26 through 6/4/26, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed: H53392097C (3007469 and 3007389) with a deficiency was issued at F689 at PAST NON-COMPLIANCE and a deficiency issued at F656 at current noncompliance. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however a plan of correction is required for the deficiency issued at F656. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F0689	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

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F0689 SS = SQC-J	Continued from page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to implement interventions to reduce the risk of falls for 1 of 3 residents (R1) reviewed for accidents and supervision. R1's care plan directed bed mobility with assistance of two staff. On 5/4/26, R1 fell out of her bed while one staff provided cares without assistance. This resulted in R1's left hip fracture, pain, and fear. The immediate jeopardy (IJ) began on 5/4/26 when nursing assistant (NA)-A provided cares, including bed mobility, without the assistance of another staff person. R1's care plan, dated 4/28/26, directed assistance of two staff for bed mobility. The IJ was removed on 5/5/26 when the facility provided education to staff regarding following care plans, audits to monitor staff performance and policy review. The administrator, director of nursing (DON) and regional nurse were notified of the IJ on 6/4/26 at 1:10 p.m. The immediate jeopardy was corrected on 5/5/26 and the deficient practice corrected on 5/15/26 prior to the start of the survey and was therefore Past Noncompliance. Findings Include: R1's quarterly minimum data set (MDS), dated 2/26/26, indicated R1 had diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) due to cerebrovascular disease (condition affecting blood flow)affecting her non-dominant left side, cerebral infarction (stroke), anxiety and depression. She was dependent on staff for rolling side to side in bed. R1's care plan, dated 4/28/26, directed assistance from two staff for bed mobility. The care sheet, dated 5/4/26, directed assistance from two staff for bed mobility. A progress note, dated 5/4/26, indicated R1 had a fall at 7:45 p.m. when she was rolled to her side and fell out of bed.	F0689		

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F0689 SS = SQC-J	Continued from page 2 A progress note, dated 5/5/26, indicated R1 had a lot of pain related to her fall the prior evening and was receiving Tylenol for pain. A progress note, dated 5/6/26, indicated R1 was refusing to get out of bed due to severe pain rated 10/10. A progress note, dated 5/7/26, indicated R1 was sent to the hospital and had a left hip fracture. She did not have surgical repair and returned to the facility. R1 was prescribed Tramadol (an opioid pain medication) and Tylenol for pain. A hospital note dated 5/7/26, indicated R1 had a fall from bed and was diagnosed with a fracture of the left hip. An x-ray result, dated 5/7/26, indicated R1 had an acute sub capital femoral neck fracture (hip fracture where the break occurs at the junction below the femoral head and main neck of the thigh bone). A progress note, dated 5/7/26, indicated R1 returned to the facility with a diagnosis of left hip fracture. A progress note, dated 5/8/26, indicated R1's physician wrote an order for Tramadol for pain. A progress note, dated 5/8/26, indicated R1 remained in bed and rated pain of 5 -6/10. A progress note, dated 5/9/26, indicated R1 still had "a lot of pain". A progress note, dated 5/11/25, indicated R1 reported pain 6-7/10 and remained in bed. A progress note, dated 5/13/26, indicated R1 complained of pain 5-7/10 and remained in bed. A progress note, dated 5/14/26, indicated R1 continued to report pain to left hip of 6-7/10 and	F0689		

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F0689 SS = SQC-J	Continued from page 3 stayed in bed. A provider note dated 5/27/26, indicated R1 had persistent left hip pain, worse with movement/rolling, at times severe. Tylenol provided minimal relief. During an interview on 6/3/26, at 12:30 p.m., R1 stated there was supposed to be two staff to provide her cares in bed. She stated NA-A assisted her to her right side; she fell between the bed and the wall, hitting the radiator, and landed on her belly. She was in "a lot of pain" and it was "very, very traumatic". Since the incident she felt "afraid during cares". She went to the hospital for an x-ray and learned her left hip was fractured. During an observation on 6/3/26, at 12:46 p.m., two staff transferred R1 from the commode to her bed via full body mechanical lift. R1 was observed to reach toward her left hip, wince, and say "ouch". During an interview on 6/3/26, at 2:47 p.m., licensed practical nurse (LPN)-A stated R1 should have two staff to assist with all bed mobility. She stated she was not aware NA-A needed assistance on 5/4/26 until after the fall occurred. During an interview on 6/3/26, at 3:05 p.m., NA-A stated she was aware R1 required two staff for bed mobility but she proceeded without the assistance of another staff on 5/4/26 with R1 due to staff being occupied at the time and R1 becoming frustrated due to waiting. She stated she assisted R1 to roll onto her right side. R1's left leg went over too far and R1 fell to the floor from her bed, landing face down on the floor. She stated this could have been prevented. During an interview on 6/4/26, at 8:50 a.m., the director of nursing (DON) stated R1's bed mobility should have been performed as assist of two, as the care sheet directed and R1's fall from bed was preventable. During an interview on 6/4/26, at 9:04 a.m., the primary care physician (PCP) for R1 stated R1 has been less mobile than prior to her fall on 5/4/26. He stated pain was managed with Tylenol and Tramadol. The fall was likely preventable since the staff	F0689		

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F0689 SS = SQC-J	Continued from page 4 member was not following the care plan at the time of the incident. The past noncompliance immediate jeopardy began on 5/4/26. The immediate jeopardy was removed on 5/5/26 and the deficient practice corrected by 5/15/26 after the facility implemented a systemic plan that included the following actions: -Re-educated all staff on assistance with activities of daily living (ADL) and following care plans. -Reviewed the ADL policy and the fall policy. -Tested the staff to ensure understanding of the re-education. -The Quality Assessment Performance Improvement (QAPI) committee met and reviewed the incident on 5/27/26. -Reviewed and evaluated resident care plans for interventions to reduce the risk of falls.	F0689		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must	F0656	"Past Noncompliance - no plan of correction required"	

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F0656 SS = D	Continued from page 5 indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to develop the care plan for 1 of 3 residents (R3) reviewed for care plans when R3's care sheet directed staff to transfer with a full body mechanical lift, but the staff transferred her with a mechanical standing lift. Findings include: During an observation on 6/3/26, at 3:40 p.m., nursing assistant (NA)-B and NA-C transferred R3 from her electric wheelchair to the tub chair using a mechanical standing lift. R3's care plan, dated 4/24/26, directed transfer status as assist of two, using a full body mechanical lift and large sling. R3's annual minimum data set (MDS), dated 5/20/26, indicated she had diagnoses of heart failure, critical illness polyneuropathy (debilitating complication of severe systemic disease in the intensive care unit) and muscle weakness. The care sheet for R3, dated 5/21/26, directed	F0656		

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Benedictine Living Community Mother of Mercy	**230 CHURCH AVENUE, BOX 676 , ALBANY, Minnesota, 56307**

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F0656 SS = D	Continued from page 6 assistance of two with a full body mechanical lift and large sling. During an interview on 6/3/26, at 3:27 p.m., R3 stated the staff transferred her with a full body mechanical lift each morning and used the mechanical stand assist lift throughout the day. During an interview on 6/3/26, at 4:14 p.m., licensed practical nurse (LPN)-B stated care provided must follow the care plan. She stated R3 should always be transferred with the full body mechanical lift. During an interview on 6/3/26, at 4:19 p.m., NA-B stated the care sheets indicated care required for each resident. She stated the sheet directed to use a full body mechanical lift, but she was a stand assist lift as well. She stated it was important to know the care required for the residents' safety. During an interview on 6/3/26, at 4:26 p.m., NA-C stated the care sheets provided the information needed to care for each resident. The sheet says full body mechanical lift but "that's not actually what it is." She started R3 transferred with the full body mechanical lift in the morning, and the stand assist lift the rest of the day. She stated the care sheets should be followed for people so they don't get hurt and they get the care they need. During an interview on 6/3/26, at 4:32 p.m., nurse manager (NM)-A stated care is directed through care sheets and R3 required assistance of two staff and a full body mechanical lift for all transfers at all times. During an interview on 6/3/26, at 4:48 p.m., the director of nursing (DON) stated the NA's should use the care sheets as they reflect the care plan and R3 should have been transferred with the full body mechanical lift at all times. During an interview on 6/4/26, at 8:50 a.m., the DON stated there was a recent change in record systems and it appeared there was a transcription error on the care sheets. The facility policy Comprehensive Assessment and Care Planning policy, dated 2017, directed all	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Living Community Mother of Mercy	**230 CHURCH AVENUE, BOX 676 , ALBANY, Minnesota, 56307**

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F0656 SS = D	Continued from page 7 person-centered care plan interventions will be implemented by qualified personnel. Interventions may be communicated through the electronic health record, resident profile, assignment sheets, and/or verbal communication.	F0656		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 15, 2026

Administrator
Benedictine Living Community Mother of Mercy
230 CHURCH AVENUE, BOX 676
ALBANY, MN 56307

Re: Event ID: 23477A-H1

Dear Administrator:

The above facility survey was completed on June 4, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/04/2026**

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20000	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 6/3/26 through 6/4/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during the survey: H53392097C (3007469 and 3007389). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal	20000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/04/2026**

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20000	Continued from page 1 software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 26, 2026

Administrator
Benedictine Living Community Mother of Mercy
230 Church Avenue, Box 676
Albany, MN 56307

RE: CCN: 245339

Cycle Start Date: June 4, 2026

*****This letter (posted June 26, 2026) will replace the letter dated June 15, 2026. The Remedies have been changed because the IJ is issued at past non-compliance (PNC) and therefore is already corrected. The NATCEP loss recommendations remain the same because the IJ includes Substandard Quality of Care (SQC). *****

Dear Administrator:

On June 4, 2026, a survey was completed at your facility by the Minnesota Department of 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 isolated deficiencies that constituted immediate jeopardy (Level J), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On May 5, 2026, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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)).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective **September 4, 2026**.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 4, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 4, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

- Civil money penalty. (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Mother of Mercy - Benedictine Living Community is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 4, 2026. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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.

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 4, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

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.

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.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

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F0000	INITIAL COMMENTS On 6/3/26 through 6/4/26, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed: H53392097C (3007469 and 3007389) with a deficiency was issued at F689 at PAST NON-COMPLIANCE and a deficiency issued at F656 at current noncompliance. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however a plan of correction is required for the deficiency issued at F656. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F0689	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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.

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

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F0689 SS = SQC-J	Continued from page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to implement interventions to reduce the risk of falls for 1 of 3 residents (R1) reviewed for accidents and supervision. R1's care plan directed bed mobility with assistance of two staff. On 5/4/26, R1 fell out of her bed while one staff provided cares without assistance. This resulted in R1's left hip fracture, pain, and fear. The immediate jeopardy (IJ) began on 5/4/26 when nursing assistant (NA)-A provided cares, including bed mobility, without the assistance of another staff person. R1's care plan, dated 4/28/26, directed assistance of two staff for bed mobility. The IJ was removed on 5/5/26 when the facility provided education to staff regarding following care plans, audits to monitor staff performance and policy review. The administrator, director of nursing (DON) and regional nurse were notified of the IJ on 6/4/26 at 1:10 p.m. The immediate jeopardy was corrected on 5/5/26 and the deficient practice corrected on 5/15/26 prior to the start of the survey and was therefore Past Noncompliance. Findings Include: R1's quarterly minimum data set (MDS), dated 2/26/26, indicated R1 had diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) due to cerebrovascular disease (condition affecting blood flow)affecting her non-dominant left side, cerebral infarction (stroke), anxiety and depression. She was dependent on staff for rolling side to side in bed. R1's care plan, dated 4/28/26, directed assistance from two staff for bed mobility. The care sheet, dated 5/4/26, directed assistance from two staff for bed mobility. A progress note, dated 5/4/26, indicated R1 had a fall at 7:45 p.m. when she was rolled to her side and fell out of bed.	F0689		

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F0689 SS = SQC-J	Continued from page 2 A progress note, dated 5/5/26, indicated R1 had a lot of pain related to her fall the prior evening and was receiving Tylenol for pain. A progress note, dated 5/6/26, indicated R1 was refusing to get out of bed due to severe pain rated 10/10. A progress note, dated 5/7/26, indicated R1 was sent to the hospital and had a left hip fracture. She did not have surgical repair and returned to the facility. R1 was prescribed Tramadol (an opioid pain medication) and Tylenol for pain. A hospital note dated 5/7/26, indicated R1 had a fall from bed and was diagnosed with a fracture of the left hip. An x-ray result, dated 5/7/26, indicated R1 had an acute sub capital femoral neck fracture (hip fracture where the break occurs at the junction below the femoral head and main neck of the thigh bone). A progress note, dated 5/7/26, indicated R1 returned to the facility with a diagnosis of left hip fracture. A progress note, dated 5/8/26, indicated R1's physician wrote an order for Tramadol for pain. A progress note, dated 5/8/26, indicated R1 remained in bed and rated pain of 5 -6/10. A progress note, dated 5/9/26, indicated R1 still had "a lot of pain". A progress note, dated 5/11/25, indicated R1 reported pain 6-7/10 and remained in bed. A progress note, dated 5/13/26, indicated R1 complained of pain 5-7/10 and remained in bed. A progress note, dated 5/14/26, indicated R1 continued to report pain to left hip of 6-7/10 and	F0689		

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F0689 SS = SQC-J	Continued from page 3 stayed in bed. A provider note dated 5/27/26, indicated R1 had persistent left hip pain, worse with movement/rolling, at times severe. Tylenol provided minimal relief. During an interview on 6/3/26, at 12:30 p.m., R1 stated there was supposed to be two staff to provide her cares in bed. She stated NA-A assisted her to her right side; she fell between the bed and the wall, hitting the radiator, and landed on her belly. She was in "a lot of pain" and it was "very, very traumatic". Since the incident she felt "afraid during cares". She went to the hospital for an x-ray and learned her left hip was fractured. During an observation on 6/3/26, at 12:46 p.m., two staff transferred R1 from the commode to her bed via full body mechanical lift. R1 was observed to reach toward her left hip, wince, and say "ouch". During an interview on 6/3/26, at 2:47 p.m., licensed practical nurse (LPN)-A stated R1 should have two staff to assist with all bed mobility. She stated she was not aware NA-A needed assistance on 5/4/26 until after the fall occurred. During an interview on 6/3/26, at 3:05 p.m., NA-A stated she was aware R1 required two staff for bed mobility but she proceeded without the assistance of another staff on 5/4/26 with R1 due to staff being occupied at the time and R1 becoming frustrated due to waiting. She stated she assisted R1 to roll onto her right side. R1's left leg went over too far and R1 fell to the floor from her bed, landing face down on the floor. She stated this could have been prevented. During an interview on 6/4/26, at 8:50 a.m., the director of nursing (DON) stated R1's bed mobility should have been performed as assist of two, as the care sheet directed and R1's fall from bed was preventable. During an interview on 6/4/26, at 9:04 a.m., the primary care physician (PCP) for R1 stated R1 has been less mobile than prior to her fall on 5/4/26. He stated pain was managed with Tylenol and Tramadol. The fall was likely preventable since the staff	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

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F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must	F0656		

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F0656 SS = D	Continued from page 5 indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to develop the care plan for 1 of 3 residents (R3) reviewed for care plans when R3's care sheet directed staff to transfer with a full body mechanical lift, but the staff transferred her with a mechanical standing lift. Findings include: During an observation on 6/3/26, at 3:40 p.m., nursing assistant (NA)-B and NA-C transferred R3 from her electric wheelchair to the tub chair using a mechanical standing lift. R3's care plan, dated 4/24/26, directed transfer status as assist of two, using a full body mechanical lift and large sling. R3's annual minimum data set (MDS), dated 5/20/26, indicated she had diagnoses of heart failure, critical illness polyneuropathy (debilitating complication of severe systemic disease in the intensive care unit) and muscle weakness. The care sheet for R3, dated 5/21/26, directed	F0656		

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F0656 SS = D	Continued from page 6 assistance of two with a full body mechanical lift and large sling. During an interview on 6/3/26, at 3:27 p.m., R3 stated the staff transferred her with a full body mechanical lift each morning and used the mechanical stand assist lift throughout the day. During an interview on 6/3/26, at 4:14 p.m., licensed practical nurse (LPN)-B stated care provided must follow the care plan. She stated R3 should always be transferred with the full body mechanical lift. During an interview on 6/3/26, at 4:19 p.m., NA-B stated the care sheets indicated care required for each resident. She stated the sheet directed to use a full body mechanical lift, but she was a stand assist lift as well. She stated it was important to know the care required for the residents' safety. During an interview on 6/3/26, at 4:26 p.m., NA-C stated the care sheets provided the information needed to care for each resident. The sheet says full body mechanical lift but "that's not actually what it is." She started R3 transferred with the full body mechanical lift in the morning, and the stand assist lift the rest of the day. She stated the care sheets should be followed for people so they don't get hurt and they get the care they need. During an interview on 6/3/26, at 4:32 p.m., nurse manager (NM)-A stated care is directed through care sheets and R3 required assistance of two staff and a full body mechanical lift for all transfers at all times. During an interview on 6/3/26, at 4:48 p.m., the director of nursing (DON) stated the NA's should use the care sheets as they reflect the care plan and R3 should have been transferred with the full body mechanical lift at all times. During an interview on 6/4/26, at 8:50 a.m., the DON stated there was a recent change in record systems and it appeared there was a transcription error on the care sheets. The facility policy Comprehensive Assessment and Care Planning policy, dated 2017, directed all	F0656		

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F0656 SS = D	Continued from page 7 person-centered care plan interventions will be implemented by qualified personnel. Interventions may be communicated through the electronic health record, resident profile, assignment sheets, and/or verbal communication.	F0656		

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20000	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 6/3/26 through 6/4/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during the survey: H53392097C (3007469 and 3007389). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal	20000		

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

Minnesota Department of Health

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20000	Continued from page 1 software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		

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F0000	INITIAL COMMENTS On 6/3/26 through 6/4/26, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed: H53392097C (3007469 and 3007389) with a deficiency was issued at F689 at PAST NON-COMPLIANCE and a deficiency issued at F656 at current noncompliance. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however a plan of correction is required for the deficiency issued at F656. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		06/16/2026
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F0689	"Past Noncompliance - no plan of correction required"	06/22/2026

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 reverse for further 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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F0689 SS = SQC-J	Continued from page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to implement interventions to reduce the risk of falls for 1 of 3 residents (R1) reviewed for accidents and supervision. R1's care plan directed bed mobility with assistance of two staff. On 5/4/26, R1 fell out of her bed while one staff provided cares without assistance. This resulted in R1's left hip fracture, pain, and fear. The immediate jeopardy (IJ) began on 5/4/26 when nursing assistant (NA)-A provided cares, including bed mobility, without the assistance of another staff person. R1's care plan, dated 4/28/26, directed assistance of two staff for bed mobility. The IJ was removed on 5/5/26 when the facility provided education to staff regarding following care plans, audits to monitor staff performance and policy review. The administrator, director of nursing (DON) and regional nurse were notified of the IJ on 6/4/26 at 1:10 p.m. The immediate jeopardy was corrected on 5/5/26 and the deficient practice corrected on 5/15/26 prior to the start of the survey and was therefore Past Noncompliance. Findings Include: R1's quarterly minimum data set (MDS), dated 2/26/26, indicated R1 had diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) due to cerebrovascular disease (condition affecting blood flow)affecting her non-dominant left side, cerebral infarction (stroke), anxiety and depression. She was dependent on staff for rolling side to side in bed. R1's care plan, dated 4/28/26, directed assistance from two staff for bed mobility. The care sheet, dated 5/4/26, directed assistance from two staff for bed mobility. A progress note, dated 5/4/26, indicated R1 had a fall at 7:45 p.m. when she was rolled to her side and fell out of bed.	F0689		06/22/2026

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F0689 SS = SQC-J	Continued from page 2 A progress note, dated 5/5/26, indicated R1 had a lot of pain related to her fall the prior evening and was receiving Tylenol for pain. A progress note, dated 5/6/26, indicated R1 was refusing to get out of bed due to severe pain rated 10/10. A progress note, dated 5/7/26, indicated R1 was sent to the hospital and had a left hip fracture. She did not have surgical repair and returned to the facility. R1 was prescribed Tramadol (an opioid pain medication) and Tylenol for pain. A hospital note dated 5/7/26, indicated R1 had a fall from bed and was diagnosed with a fracture of the left hip. An x-ray result, dated 5/7/26, indicated R1 had an acute sub capital femoral neck fracture (hip fracture where the break occurs at the junction below the femoral head and main neck of the thigh bone). A progress note, dated 5/7/26, indicated R1 returned to the facility with a diagnosis of left hip fracture. A progress note, dated 5/8/26, indicated R1's physician wrote an order for Tramadol for pain. A progress note, dated 5/8/26, indicated R1 remained in bed and rated pain of 5 -6/10. A progress note, dated 5/9/26, indicated R1 still had "a lot of pain". A progress note, dated 5/11/25, indicated R1 reported pain 6-7/10 and remained in bed. A progress note, dated 5/13/26, indicated R1 complained of pain 5-7/10 and remained in bed. A progress note, dated 5/14/26, indicated R1 continued to report pain to left hip of 6-7/10 and	F0689		06/22/2026

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F0689 SS = SQC-J	Continued from page 4 member was not following the care plan at the time of the incident. The past noncompliance immediate jeopardy began on 5/4/26. The immediate jeopardy was removed on 5/5/26 and the deficient practice corrected by 5/15/26 after the facility implemented a systemic plan that included the following actions: -Re-educated all staff on assistance with activities of daily living (ADL) and following care plans. -Reviewed the ADL policy and the fall policy. -Tested the staff to ensure understanding of the re-education. -The Quality Assessment Performance Improvement (QAPI) committee met and reviewed the incident on 5/27/26. -Reviewed and evaluated resident care plans for interventions to reduce the risk of falls.	F0689		06/22/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must	F0656	The care plan and care sheet for Resident R3 were immediately reviewed and corrected to accurately reflect the transfer method of assist of two staff with a mechanical lift and sling. CNA's responsible for R3's care were re-educated immediately following the event on the correct transfer procedure. The care plan and care sheet for Resident R3 were immediately reviewed and corrected to accurately reflect the transfer method of assist of two staff with a mechanical lift and sling. CNA's responsible for R3's care were re-educated immediately following the event on the correct transfer procedure. The facility implemented a dual-verification process for all care plan updates and care sheet revisions, including during and after electronic record system transitions. Nursing leadership updated the care-planning workflow to require real-time reconciliation between the electronic care plan and printed/posted care sheets. All nursing staff were re-educated on or by 6.29.26 or before the next scheduled shift, on the requirement to follow the written care plan and to immediately report any discrepancies. The DON or designee will audit one area of the care plan for 3 residents per week for 6 weeks, to verify	06/29/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0656 SS = D	Continued from page 5 indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to develop the care plan for 1 of 3 residents (R3) reviewed for care plans when R3's care sheet directed staff to transfer with a full body mechanical lift, but the staff transferred her with a mechanical standing lift. Findings include: During an observation on 6/3/26, at 3:40 p.m., nursing assistant (NA)-B and NA-C transferred R3 from her electric wheelchair to the tub chair using a mechanical standing lift. R3's care plan, dated 4/24/26, directed transfer status as assist of two, using a full body mechanical lift and large sling. R3's annual minimum data set (MDS), dated 5/20/26, indicated she had diagnoses of heart failure, critical illness polyneuropathy (debilitating complication of severe systemic disease in the intensive care unit) and muscle weakness. The care sheet for R3, dated 5/21/26, directed	F0656	Continued from page 5 that care sheets match the care plan and that staff are using the correct transfer method and as needed thereafter based on QAPI review. Audit results will be reviewed by the QAPI Committee monthly. The facility will achieve and maintain substantial compliance by June 29th 2026.	06/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

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F0656 SS = D	Continued from page 6 assistance of two with a full body mechanical lift and large sling. During an interview on 6/3/26, at 3:27 p.m., R3 stated the staff transferred her with a full body mechanical lift each morning and used the mechanical stand assist lift throughout the day. During an interview on 6/3/26, at 4:14 p.m., licensed practical nurse (LPN)-B stated care provided must follow the care plan. She stated R3 should always be transferred with the full body mechanical lift. During an interview on 6/3/26, at 4:19 p.m., NA-B stated the care sheets indicated care required for each resident. She stated the sheet directed to use a full body mechanical lift, but she was a stand assist lift as well. She stated it was important to know the care required for the residents' safety. During an interview on 6/3/26, at 4:26 p.m., NA-C stated the care sheets provided the information needed to care for each resident. The sheet says full body mechanical lift but "that's not actually what it is." She started R3 transferred with the full body mechanical lift in the morning, and the stand assist lift the rest of the day. She stated the care sheets should be followed for people so they don't get hurt and they get the care they need. During an interview on 6/3/26, at 4:32 p.m., nurse manager (NM)-A stated care is directed through care sheets and R3 required assistance of two staff and a full body mechanical lift for all transfers at all times. During an interview on 6/3/26, at 4:48 p.m., the director of nursing (DON) stated the NA's should use the care sheets as they reflect the care plan and R3 should have been transferred with the full body mechanical lift at all times. During an interview on 6/4/26, at 8:50 a.m., the DON stated there was a recent change in record systems and it appeared there was a transcription error on the care sheets. The facility policy Comprehensive Assessment and Care Planning policy, dated 2017, directed all	F0656		06/29/2026

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F0656 SS = D	Continued from page 7 person-centered care plan interventions will be implemented by qualified personnel. Interventions may be communicated through the electronic health record, resident profile, assignment sheets, and/or verbal communication.	F0656		06/29/2026

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20000	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 6/3/26 through 6/4/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during the survey: H53392097C (3007469 and 3007389). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal	20000		06/16/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/04/2026**

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20000	Continued from page 1 software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		06/16/2026