Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 28, 2026

Administrator
BENEDICTINE LIVING COMMUNITY OWATONNA
2255 30TH STREET NW
OWATONNA, MN 55060

RE: CCN: 245426
Cycle Start Date: May 13, 2026

Dear Administrator:

On May 13, 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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 12, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 12, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 12, 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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 12, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, BENEDICTINE LIVING COMMUNITY OWATONNA will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 12, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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.

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:

Tina Larsen, Regional Operations Supervisor, Rapid Response
Health Regulation Division

Minnesota Department of Health
St. Cloud District Office
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Tina.Larsen@state.mn.us
Office: (320) 223-7374 Mobile: (320) 423-0619

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

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 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 location and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 13, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

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May 28, 2026

Administrator
BENEDICTINE LIVING COMMUNITY OWATONNA
2255 30TH STREET NW
OWATONNA, MN 55060

Re: State Nursing Home Licensing Orders
Event ID: 231A0B-H1

Dear Administrator:

The above facility survey was completed on May 13, 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 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:

Tina Larsen, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
St. Cloud District Office
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Tina.Larsen@state.mn.us
Office: (320) 223-7374 Mobile: (320) 423-0619

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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245426	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OWATONNA	2255 30TH STREET NW , OWATONNA, Minnesota, 55060

(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 5/12/26 to 5/13/26, an abbreviated survey was completed by a surveyor from the Minnesota Department of Health (MDH) to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, the Requirements for Long Term Care Facilities. The following complaints were reviewed: H54262047C (3006067); with non-compliance cited at F684, F755. H54261699C (2996678); with non-compliance cited at F655, F684, F690. 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		
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to educate on risk and	F0684	R1 and R2 no longer reside in the facility. All facility residents with orders for anticoagulation medications, compression wraps, and surgical incisions/wounds were reviewed to ensure orders and active monitoring were in place to prevent the risk of clotting and deep vein thrombosis (DVT). All residents will be reviewed in daily facility IDT meeting to ensure comprehensive clinical review of hospital discharge documentation, physician orders, anticoagulation therapy, compression therapy orders, and post-surgical monitoring requirements. All licensed nursing staff will receive education on the following: Risk and prevention of deep vein	06/09/2026

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.

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

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F0684 SS = G	Continued from page 1 prevention of deep vein thrombosis (DVT); failed to ensure applied compression wraps for DVT prevention were clarified upon admission for ongoing use; and failed to ensure physician orders for resumption of anticoagulant (blood thinning) medication were acted upon timely to help reduce the clotting risk for 1 of 3 residents (R1) reviewed. R1 was subsequently hospitalized and died due to severe blood clotting with an ischemic (insufficient blood flow) leg and pulmonary embolism (clot in the lung) resulting in actual harm for R1. In addition, the facility failed to ensure surgical incisions were adequately monitored by nursing staff to reduce the risk of complication (i.e., delayed response to infection) for 1 of 3 residents (R2) reviewed who had surgical wounds. Findings include: R1: R1's Hospitalist Discharge Summary, dated 4/1/26, identified R1 would be transitioned to the care center and listed a principal problem of acute cholecystitis (gallbladder inflammation). R1's other active problems included high blood pressure, heart failure, and atrial fibrillation (irregular heart rhythm). R1 was described as a 93-year-old female who admitted to the hospital on 3/25/26 with acute cholecystitis and underwent surgery for this condition. R1 then developed atrial fibrillation with rapid ventricular rate (RVR). The summary outlined, "Eliquis (anticoagulant – blood thinner) on hold postoperatively." R1 discharged the hospital with a Jackson Pratt (JP) drain (a tube placed into a wound to allow drainage of fluid) in place and would follow up in the general surgery clinic. The note added, "She will hold Eliquis until JP drain is removed." R1's corresponding After Discharge Orders, dated 4/1/26, identified R1's hospital discharge orders. These listed a section labeled, "Discharge Medications" that contained two medications listed under the heading, "PAUSE taking these medications." One of the medications listed under this heading was Eliquis 2.5 milligrams (mg) with directions below, "Wait to take this until your doctor or other care provider tells you to start again. After JP [Jackson Pratt] drain is out." The orders included no other anticoagulant medications or directions for compression wraps to be applied. R1's progress note, dated 4/1/26, identified R1 admitted to the care center, and she was alert and oriented. R1 had multiple medical conditions including atrial fibrillation and she had a JP drain in	F0684	Continued from page 1 thrombosis (DVT), compression wraps, resumption of anticoagulation (blood thinning) medication management, timely implementation of physician orders (POL_NS901), medication reconciliation, and surgical incision monitoring. DON or designee will complete audit of resident orders to ensure medication reconciliation is completed, anticoagulant orders are accurately transcribed and implemented, compression therapy orders are verified and implemented and surgical incisions are adequately monitored. Audits will be completed three times a week for 6 weeks with any concerns being brought to the DON for immediate follow-up. Results will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review if substantial compliance is not met.	06/09/2026

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F0684 SS = G	Continued from page 2 place with bloody drainage present. The note recorded, "No edema. Wearing compression socks. HR [heart rate] irregular." R1's vital signs were stable on one liter of oxygen (O2). Licensed practical nurse (LPN)-C authored the note. A subsequent note, dated 4/1/26, identified R1 was seen by physical therapy (PT) and initial evaluations were completed. The note recorded, "Assist of 2 pivot transfers. Assist of 2 toileting and self-cares." R1's progress note, dated 4/3/26, identified R1 was seen by occupational therapy (OT) and identified, "Transfers: 1A [one assist] pivot w/ 4WW [walker] ... Self Cares: Extensive assist ... Toileting: 1A pivot w/ grab bars." R1's Progress Note, dated 4/6/26, identified R1 was seen by the general surgery service for post-operative follow-up. The note identified the surgery was on 3/26/26, and the patient was "doing well" and the JP drain had not had output for "a few days." The JP drain was removed, and the site was reapproximated with Steri-Strips. The note recorded, "[R1] is doing well postoperatively ... At this point the patient is dismissed from our surgical service." The note identified sections below the dictation which read, "Orders Placed," and "Medication Changes," but these were both answered with text reading, "None." The note did not address R1's Eliquis, which remained on hold since she was admitted to the care center six days prior. R1's admission Minimum Data Set (MDS), dated 4/7/26, identified R1 had intact cognition along with several medical conditions including heart failure and atrial fibrillation. The MDS identified R1's consumed medications during the evaluation period, where the space to record anticoagulant consumption was left un-checked (i.e., not administered). R1's progress note, dated 4/8/26, identified R1 was seen by therapy and was now an assist of one for walking to and from the bathroom with a gait belt and walker. The note identified, "[R1] is to walk 3x day with a [walker] and 1 A with gait belt and [wheelchair] follow." R1's H&P (History & Physical), dated 4/10/26, identified R1 was seen by the medical doctor (MD)-A for a routine nursing home visit due to admission. R1 had been recently hospitalized for sepsis (life-threatening response to infection) due to acute cholecystitis and had surgery. R1 developed atrial fibrillation with RVR post-operatively and was discharged to the care center on 4/1/26 with a JP	F0684		06/09/2026

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F0684 SS = G	Continued from page 3 drain in place. The note recorded, "Since discharge she feels generally well and has no nausea. She has significant fatigue ... she notes an irregular heartbeat." MD-A completed a physical examination of R1 which outlined, "Extremities: Normal without edema." The note listed a section labeled, "ASSESSMENT/PLAN" that reviewed each medical condition and subsequent orders for them. This included, "Atrial Fibrillation Paroxysmal (HCC)," and dictation that read, "Persistent with mildly elevated ventricular rate after recent sepsis hospitalization ... Apixaban [Eliquis] was to be restarted when JP drain was removed. I wrote that order today." R1's subsequent order, dated 4/10/26, identified directions which included taking Eliquis 2.5 mg orally twice a day. The order was signed by MD-A on 4/10/26 (four days after the JP drain was removed) at 9:31 p.m., and the fax was time-stamped it was received by the care center at 9:33 p.m. R1's Medication Administration Record (MAR), dated 4/2026, identified R1's administered medications for the month period. This included an order for Eliquis 2.5 mg twice a day with dates recorded, "04/11/2026 - 4/15/2026." The medication was recorded as not being administered on 4/11/26 for either dose with comments written, "Other ... pharmacy will deliver med ASAP," and "Drug/Item unavailable." R1's first recorded dose of the Eliquis was on 4/12/26 (two days after being ordered) in the morning hours. The medication was provided until 4/14/26 (evening) and the space to record the morning dose on 4/15/26 was left blank with nothing identified. Further, R1's Treatment Administration Record (TAR) lacked any evidence of use of compression wraps or TEDs despite R1 admitting from the hospital with them on. R1's medical record lacked evidence R1 had been educated on DVT prevention including potential exercises R1 could do on her own while in bed to help prevent blood clots (i.e., ankle pumps); it lacked evidence R1's compression wraps, which were present on her upon admission, were clarified with the provider to determine if these should continue given R1 being off her anticoagulant medication and being at increased risk of blood clot; and lacked evidence of any shift-to-shift nursing monitoring (i.e., calf measurements, leg pain, skin discolorations) for a potential blood clot despite R1 being off her anticoagulant medication. Further, the record lacked evidence that the care center had acted upon the hospital's discharge order and notified the physician to resume the Eliquis when the JP drain was removed prior to 4/10/26, despite the drain being removed on 4/6/26 (four days	F0684		06/09/2026

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F0684 SS = G	Continued from page 4 earlier). R1's progress note, dated 4/15/26, identified the nursing assistant (NA) reported R1 sat on her bedside and was unable to move her left leg. The note recorded the leg, " ... appeared to be difference [sic] in color and cooler than right side ... resident said that she couldn't feel sensation on left foot. Called for ambulance and called daughter ... left via ambulance ...." R1's Emergency Department (ED) Encounter, dated 4/15/26, identified R1 presented with decreased sensation in her left leg with the leg being, "cool and dusky with a visible color change. Unable to Doppler pulses extending up to the popliteal. [back of the knee]" The note identified a CT was completed which identified an acute pulmonary embolism [blood clot in the lung] and near complete occlusion of the entire left iliofemoral and femoropopliteal system. The note identified when R1 arrived at the acute care hospital ED, she was having pain in her left hip that was, " ... still severe at 10/10." R1 was given heparin (an anticoagulant) via IV in the ED and the note identified, "She is being treated with heparin and will be sent to the OR emergently with vascular surgery for femoral cutdown, thrombectomy, [removal of blood clots], and likely fasciotomies [removal of facia] given the degree of ischemia. [death of tissue]. Both Dr. [name] from vascular surgery and I did impress upon the patient and her family the gravity of the situation and that she may well die in surgery but would almost certainly die without it." R1 agreed to the operation. On 5/11/26 at 1:21 p.m., R1's family member (FM)-A was interviewed. They explained that R1 was admitted to the care center following a hospitalization for gallbladder surgery and was not considered to be in terminal condition during the hospitalization or while admitted to the care center. R1 planned to return home to their assisted living facility (ALF) when they completed rehabilitation therapy at the care center. FM-A explained R1 had been on Eliquis prior to the hospitalization but it was held for her surgery and R1 discharged from the hospital to the nursing home with orders to resume the medication from their understanding. However, some issue happened that caused R1 to go for "almost two weeks" without the medication. FM-A stated their other family member had learned the medication was re-started on 4/11/26, when they started asking staff some questions about the medication. Then on 4/15/26, R1 developed a blood clot and had to be taken to the hospital where a	F0684		06/09/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OWATONNA	2255 30TH STREET NW , OWATONNA, Minnesota, 55060

(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
F0684 SS = G	Continued from page 5 "significant clot" was found. FM-A stated R1 must have been off the medication "a fatal amount of time" as the clot, which happened on 4/15/26, caused R1 to be hospitalized and R1 then passed away while in the hospital. FM-A stated watching R1 having pain and ultimately dying in the hospital was "a very sad thing to experience" and reiterated R1 planned to return to their ALF after the care center, until this medication incident happened. When interviewed on 5/12/26 at 10:17 a.m., nursing assistant (NA)-A stated they recalled working with R1 who needed minimal assistance with most cares. NA-A stated they could not recall R1 using compression wraps or TEDs while at the care center adding, "I'm not sure on that." NA-A stated R1 ambulated using a walker but not when she first admitted to the care center, adding the ambulation was "more at the end" before she was hospitalized. NA-A stated they heard R1 had developed a blood clot and had to be hospitalized but was unsure of the details around it. When interviewed on 5/12/26 at 10:24 a.m., licensed practical nurse (LPN)-C reviewed R1's medical record and explained she was admitted to the care center following gallbladder surgery with a JP drain in place. LPN-C stated compression wraps or TEDs would need a physician order for use and R1 didn't have them ordered upon admission. LPN-C reviewed the progress note they authored (dated 4/1/26), which identified R1 had them physically on when she admitted, and verified the record lacked evidence using them had been clarified with the physician. LPN-C adding that it "should be a group" of people who could have acted on that. LPN-C stated they did not recall R1 using compression wraps or TEDs while at the care center after she admitted and stated, "It was not followed up on." LPN-C stated monitoring for a potential blood clot would likely be charted in the "Medicare charting" progress notes, however, R1's note template did not have that listed as something to monitor. LPN-C stated if a medication, like Eliquis, was on hold from the hospital then the floor staff wouldn't always know that information, adding unless the person was here for a hip fracture or something of that nature, then staff would likely not be alert to a potential clot risk like R1 had. When questioned about who was responsible for assigning or developing the shift-to-shift monitoring notes, LPN-C stated the health unit coordinator (HUC) used to read the hospital notes and help suggest or implement some monitoring, but the position had been "patching together" for several weeks due to leaves and resignations. LPN-C then reviewed R1's Eliquis and	F0684		06/09/2026

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F0684 SS = G	Continued from page 6 stated the order to resume it was faxed to the center on 4/10/26 late in the evening and entered in the EMR to begin on 4/11/26. LPN-C acknowledged the doses on 4/11/26 were not administered and said they were unsure why it wasn't given, as a supply of Eliquis was available in the onsite emergency kit (E-kit). LPN-C stated they were unsure why there had been a delay of multiple days after the JP drain was removed, to when the Eliquis was restarted. LPN-C stated it was likely missed as the order to resume it had not been entered into the EMR for staff to ask about it: "We [floor staff] may never have known her Eliquis was on hold if we didn't look at the actual hospital summary." LPN-C stated not entering the orders on hold upon admission caused things "to be left to chance sometimes." LPN-C stated they felt all orders, including medications on hold, should be entered into the EMR so the floor staff were aware of them, adding, "The more information we have, the better." Further, LPN-C stated Eliquis was considered a high-risk medication and not getting the medication resumed for multiple days which caused missed doses, would be a concern, adding aloud, "It's significant." When interviewed on 5/12/26 at 11:23 a.m., registered nurse (RN)-A explained that when someone admitted from the hospital the HUC would take the information and enter it into the EMR. Then nurse would then verify it: "If I have time." RN-A stated if someone admitted with an order to hold Eliquis until a drain was removed, then they would place a general note in the EMR such as "an FYI-type thing." RN-A stated the need to resume it should be posted somewhere in the EMR for the floor staff to see repeatedly otherwise the order was likely to be missed. RN-A stated entering the order was not necessarily the policy of the campus but rather "something I would do." RN-A stated if someone admitted to the care center with compression wraps on but no order for them, it should be clarified right away. RN-A stated the shift-to-shift monitoring for each resident was determined by either the HUC or the floor nurse and entered into the system using the progress notes. RN-A stated they personally tried to review hospital notes on the residents, but not every nurse does that, adding some "newer nurses" seem to be very focused on the orders only and not looking at the whole situation of the resident. On 5/12/26 at 1:59 p.m., unit nurse manager (RN)-B, the director of nursing (DON), and administrator were interviewed. DON stated someone using an anticoagulant medication would more likely be monitored for bleeding risk and they would typically	F0684		06/09/2026

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F0684 SS = G	Continued from page 7 need "at least a provider recommendation" to monitor for clots before that would be entered and tracked in the EMR. DON reiterated none of the hospital discharge paperwork or subsequent physician notes directed to monitor for potential blood clots. However, DON stated if nursing had concerns about it then they could initiate a nursing order and update the medical provider. RN-B stated there was no order for compression wraps from the hospital when R1 admitted and felt maybe they were not needed anymore, adding it was "hard for me to say" if someone ever clarified it or not with the provider. DON stated if there were questions about the wraps being used or not, then someone could have reached out to the provider and clarified it. RN-B and DON also verified they were unable to locate any documentation to show R1 had been educated on the risk of blood clots and steps to reduce them. DON then reviewed R1's Eliquis and explained it wasn't an "active order" when she admitted on 4/1/26 so it would not have been entered into the EMR as it could cause a medication error. DON stated in R1's scenario that "multiple people" could have caught the order to resume it once the JP drain was removed including the medical provider who physically removed the drain itself, but they never addressed it in their note. DON stated the person who reviewed the notes on admission would be "the system" to catch this and resume the medication. When asked how it would be handled if that person was not working or resigned in the meantime, the DON replied, "I don't know if we have a fool-proof system in place for that," and suggested maybe using a "sticky note" on the desk in the office. DON verified there was no system outside of the EMR in place to ensure orders like R1's were identified and acted upon timely. DON explained the pharmacy sends medications to the campus once a day usually in the early morning hours, so an order received late at night wouldn't likely arrive the following day, however, the E-Kit was available and had some of that medication inside at the time on 4/11/26 to at least provide a dose. DON stated they would consider Eliquis to be a high-risk medication, and it should be given timely when ordered to help prevent blood clots. The DON and RN-B both acknowledged room to improve the communication surrounding this incident with R1 and the administrator expressed they felt the medical provider should have a responsibility to review medications after surgery adding they were unsure why the provider on 4/6/26 didn't address the medication then. When interviewed on 5/12/26 at 2:32 p.m., MD-A stated they were the campus' medical director and	F0684		06/09/2026

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F0684 SS = G	Continued from page 8 verified they had physically seen R1on 4/10/26 for the visit. MD-A stated they did not recall if anyone from the care center had clarified the compression wraps with them or not and expressed an order for their use was typically needed. MD-A stated either them or the nurses could catch that and have clarified it when R1 was admitted. MD-A stated use of compression wraps or TEDs was an intervention to help prevent blood clots in the legs and clarifying the order for R1 on 4/1/26 would have "[been] a reasonable thing to do." MD-A stated they did not recall providing any education to R1 on the prevention of blood clots, either. MD-A reviewed R1's Eliquis and stated they learned it was to be restarted on 4/10/26 when the visit happened but were unsure if they identified that themselves or if the nurses at the center raised the issue with them. MD-A stated when they saw R1 on 4/10/26, there was no concern for a blood clot in her leg at that time, so the clotting most likely happened after that visit. MD-A stated if R1 had her Eliquis restarted immediately after the JP drain was removed (on 4/6/26) it was "hard to say," if a clot and subsequent hospitalization could have been avoided but MD-A added, "Its possible it may have changed the outcome." MD-A stated if the medication was available in the E-Kit then a dose could have been removed and provided immediately following the order on 4/11/26 adding, "That would be a med I would administer sooner rather than later." MD-A stated it was "hard to say" if they expected to be notified by the nurses on 4/6/26 when the JP drain was removed but added that given the situation with R1 and what happened with her developing a clot it would have been "a great loop closure" to have been notified. MD-A expressed, "The takeaway [from this] is to identify loops that need to be closed and figure out the best process for doing that." MD-A stated, in hindsight, the nurses could have notified their service about the Eliquis adding, "That would have been nice, but it didn't happen." On 5/12/26 at 3:23 p.m., the dispensing pharmacist (DP)-A was interviewed and verified their service distributed the medications to the campus. DP-A stated their current formulary showed Eliquis as being available in the campus E-Kit, but they would have to check and then send a review of the "retrospective inventory" after the interview to confirm a medication supply was available on 4/11/26. DP-A stated nurses were always able to call them and ask about medication supply if they had questions about it. DP-A stated Eliquis was a medication the patient should not be without for a long period and explained the "half-life" of the medication (the time it takes for the concentration of	F0684		06/09/2026

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F0684 SS = G	Continued from page 9 that drug in your body to reduce by exactly 50%) was about 12 hours, and the medication starts working within an hour of being given. If a patient went for several days without it, then the effects of the medication would likely be totally removed from the body systems. DP-A stated having a period of multiple days unnecessarily going without the medication would make a difference with the risk of blood clots being formed adding, "It would matter something." When interviewed on 5/12/26 at 4:05 p.m., the director of therapy (DOT) stated they were not the primary therapist who worked with R1 while she was at the care center, however, was somewhat familiar with her care and services she received. DOT stated the therapist chart in their own system, and they had reviewed the notes for R1, which identified R1 as not very mobile when she first admitted but then was "progressing really well" until she discharged to the hospital. DOT verified they were unable to locate any documentation to show R1 had been educated on the risk of blood clots and subsequent prevention techniques she could do on her own such as "ankle pumps." DOT also was unable to locate any information on R1's use of compression wraps while at the care center and stated the nurses were able to facilitate those if desired or needed. DOT stated they felt the education on DVT prevention was typically provided, however, there was nothing documented for R1 to show it had happened. An e-mail correspondence received from DP-A on 5/12/26 at 5:28 p.m., identified Eliquis was available with at least one dose in the E-Kit on 4/11/26. The email identified, "It appears that the facility had a balance on hand in their [kit] to initiate therapy before the cards were delivered." A provided Physician Services policy, dated 1/2019, identified the care center would provide services related to physician services in accordance with State and Federal regulations. This included a procedure which directed, "All physician orders will be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record during that shift." R2: On 5/12/26 at 12:35 p.m., R2's family member (FM)-D was interviewed. R2 was admitted to the care center after being hospitalized for an extended period due to multiple conditions and he had used a catheter while in the hospital, but it was removed	F0684		06/09/2026

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F0684 SS = G	Continued from page 10 before he discharged to the care center on 4/13/26. FM-D stated R2 was "doing good" with using the bathroom and able to sense the need to go when he left the hospital. R2 also had some healing surgical incisions near his groin which were all intact and open-to-air (OTA). However, then they opened while at the care center and R2 had to eventually go back to the hospital due to them being re-opened and becoming infected. FM-D questioned what wound cares had been provided and how these closed, healing wounds could have re-opened. R2's progress note, dated 4/13/26, identified R2 admitted to the care center and had several medical conditions including peripheral arterial disease (PAD), acute kidney injury, chronic kidney disease (CKD), and high blood pressure. R2 needed assistance for all activities of daily living (ADLs), needed cues and reminders to ask for help, and was alert and oriented to self. The note identified R2 had been incontinent of urine and was unaware of such. Further, the note included a section labeled, "Skin," which identified, " ... two healing surgical sites in bilateral groin ... Bruising to BUE [bilateral upper extremities] ... Small scabbed area to posterior calf on LLE [left lower extremity ... All areas OTA [open to air] and not draining. No redness, swelling, or warmth to peri-wounds." R2's Care Plan, dated 4/22/26, identified all the potential or actual problems R2 had along with goals and interventions to address them. This identified a section labeled, "Category: Bowel & Bladder Function," which recorded R2 as having bladder and bowel incontinence along with interventions to address it including keeping the call light within reach, monitoring for signs of infection, providing R2 with the urinal/bedpan/commode as needed, and offering him toileting frequently. The care plan continued and listed a section labeled, "Category: Pressure Ulcer/Injury," which recorded R2 as admitting with multiple surgical incisions and being at risk of skin breakdown. The plan listed several interventions including monitoring the skin, being involved in the treatment process, and applying barrier creams if needed. R2's medical record, including progress notes and treatment records, lacked evidence of any ongoing or shift-to-shift monitoring of R2's healing surgical wounds from 4/14/26 to 4/19/26. There was no evidence they were being observed by the nurses for symptoms of infection or potential dehiscence (surgical complication where a closed wound or incision ruptures and opens). In addition, R2's Wound Management section of the electronic	F0684		06/09/2026

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F0684 SS = G	Continued from page 11 medical record (EMR) lacked any evidence the surgical incisions were being tracked or monitored. R2's progress note, dated 4/19/26, identified R2 refused morning cares and his bedding was soiled. The nurse responded and assisted R2 into the bathroom and completed a body audit. The note identified, "Writer observed right inguinal/groin with full thickness wound measuring 1.7 cm [centimeters] X 1.9 cm. Large nodule purple in color right inguinal/groin inferior to wound measuring 5 cm X 7 cm." The left groin incision was recorded as well approximated and R2's vital signs were stable. A subsequent note, dated 4/19/26, identified an SBAR (acute situation update) note was faxed to the hospital and R2's family was updated, " ... of concern of incisions." When interviewed on 5/12/26 at 1:24 p.m., nursing assistant (NA)-A stated they recalled working with R2. NA-A explained R2 needed help to use the bathroom and would, at times, refuse basic care like getting cleaned up. NA-A stated they recalled trying to reposition R2 every few hours and were unsure if he ever had skin issues or wounds adding, "I don't remember that." When interviewed on 5/12/26 at 1:27 p.m., licensed practical nurse (LPN)-C stated if someone admitted with surgical wounds then they'd have daily monitoring done when the incision dressing was changed. If the wounds were open to air, such as R2's were, then the monitoring would be done and recorded on the "Medicare charting" notes in the progress notes or on the TAR. LPN-C stated there should be an order for monitoring with any surgical incision for "at least daily [checks]." LPN-C reviewed R2's medical record and acknowledged it lacked evidence of any ongoing monitoring of the surgical incisions from 4/14/26 to 4/19/26. LPN-C stated it was important to ensure incisions, even if closed and healing, were monitored until the wound was completely resolved. LPN-C stated they saw R2's incision on 4/19/26 when it had re-opened and completed the SBAR update to the physician. LPN-C stated they were unsure what had happened or caused it to open, but R2 ended up going to the hospital a few days later to have it addressed. On 5/13/26 at 10:33 a.m., the director of nursing (DON) and administrator were interviewed. DON explained a skin observation is completed upon admission and wounds or incisions should be recorded on that evaluation. If a surgical incision was present, which was draining or had concerning presentation, then the nurses could contact the	F0684		06/09/2026

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F0684 SS = G	Continued from page 12 medical provider or onsite wound nurse to review it. DON stated the NA staff were taught to observe the skin each day with cares and felt they'd report issues if seen. DON stated the Medicare charting is determined by the MDS nurses and not everyone would get incisional monitoring included, especially if the incisions were open to air like R2's were upon admission. DON verified they were unable to locate documentation to show any monitoring of the incisions from 4/14/26 to 4/19/26 and reiterated the NA staff were taught to check the skin with daily care. A provided Prevention and Treatment of Skin Breakdown policy, dated 9/2018, identified resident skin was assessed upon admission and weekly thereafter. A resident who was at increased risk for breakdown would be provided preventative measures to reduce the potential risk of skin breakdown. A procedure was listed that outlined steps to be completed which included, "Skin is observed daily with cares. If any skin concerns are noted, they are reported to the licensed nurse." The procedure then shifted to more pressure ulcer prevention and care and lacked any specific guidance or process for surgical incision monitoring.	F0684		06/09/2026
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders.	F0655	R2 is no longer a resident in the facility. All residents admitted to the facility within the past 30 days were reviewed to ensure a baseline care plan had been developed. All licensed nursing staff will be re-educated on Comprehensive Assessments and Care Planning (POL_NS101); specifically, the development of a baseline care plan within 48 hours of admission to the facility. DON or designee will complete audit of residents to ensure baseline careplans are completed within 48 hours of admission to ensure immediate care needs are identified. Audits will be completed three times a week for 6 weeks with any concerns being brought to the DON for immediate follow-up. Results will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met	06/09/2026

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F0655 SS = D	Continued from page 13 (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to develop a baseline care plan to ensure immediate care needs for surgical incision care and his urinary incontinence were addressed for 1 of 3 residents (R2) reviewed. R2's progress note, dated 4/13/26, identified R2 admitted to the care center and had several medical conditions including peripheral arterial disease (PAD), acute kidney injury, chronic kidney disease (CKD), and high blood pressure. R2 needed assistance for all activities of daily living (ADLs), needed cues and reminders to ask for help, and was alert and oriented to self. The note identified R2 had been incontinent of urine and was unaware of such. Further, the note included a section labeled "Skin" that identified, " ... two healing surgical sites in bilateral groin ... Bruising to BUE [bilateral upper	F0655		06/09/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OWATONNA	2255 30TH STREET NW , OWATONNA, Minnesota, 55060

(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
F0655 SS = D	Continued from page 14 extremities] ... Small scabbed area to posterior calf on LLE [left lower extremity ... All areas OTA [open to air] and not draining. No redness, swelling, or warmth to peri-wounds." R2's Care Plan, dated 4/22/26, identified all the potential or actual problems R2 had, along with goals and interventions to address them. This identified a section labeled "Category: Bowel & Bladder Function" that recorded R2 as having bladder and bowel incontinence along with interventions to address it, which included keeping the call light within reach, monitoring for signs of infection, providing R2 with the urinal/bedpan/commode as needed, and offering him toileting frequently. However, this section of the care plan and its interventions were initiated on 4/20/26 (seven days after admission). The care plan continued and listed a section labeled "Category: Pressure Ulcer/Injury" that recorded R2 as admitting with multiple surgical incisions and being at risk of skin breakdown. The plan listed several interventions including monitoring the skin, being involved in the treatment process, and applying barrier creams if needed. However, again, this section and its interventions were initiated on 4/20/26 (seven days after admission). R2's medical record lacked evidence that a comprehensive baseline care plan had been developed within 48 hours of admission to address these areas of R2's care despite him having active surgical wounds and being incontinent of urine upon admission as recorded in the progress notes. When interviewed on 5/12/26 at 1:24 p.m., nursing assistant (NA)-A stated they recalled working with R2. NA-A explained R2 needed help to use the bathroom and would, at times, refuse basic cares like getting cleaned up. NA-A stated they recalled trying to reposition R2 every few hours and were unsure if he ever had skin issues or wounds adding, "I don't remember that." When interviewed on 5/12/26 at 1:27 p.m., licensed practical nurse (LPN)-C stated the facility did not use a specific baseline care plan but rather just started to build the comprehensive one upon admission. LPN-C stated care plans were made usually by the nurse managers, director of nursing (DON) and social worker team as they reviewed the evaluations the floor staff completed. LPN-C reviewed R2's care plan and verified the skin and bladder/bowel sections were initiated on 4/20/26 which was a week after R2 was admitted to the center. LPN-C stated the baseline care plan should	F0655		06/09/2026

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F0655 SS = D	Continued from page 15 be done within "a few days" after admission. LPN-C stated having a baseline care plan was important as it assisted the staff with caring for the person in the early part of their admission. On 5/13/26 at 10:33 a.m., the DON and administrator were interviewed. DON explained that the MDS (Minimum Data Set) nurses helped complete the care plan by reviewing the floor staff observations and evaluations which included a toileting plan, if needed. DON verified there was not a separate baseline care plan template used and that R2's skin or bladder/bowel plans were not initiated until 4/20/26. DON stated they should have been initiated within 48 hours after admission to the care center but with weekend admission it could "take a little bit longer" at times. DON stated they would be doing education on this to the staff and added having a baseline care plan was important for the staff to know how to care for the resident. A provided Comprehensive Assessments and Care Planning policy, dated 2/2026, identified the assessment process of a resident begins with the development of the baseline care plan within the first 48 hours of admission. The plan should have the minimum healthcare information needed to care for them on admission including but not limited to their initial goals, physician orders, dietary orders, and social services. The policy continued, "The baseline care plan reflects the resident's stated goals and objective, and includes interventions that address his or her current needs."	F0655		06/09/2026
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F0690	R2 is no longer a resident in the facility. All facility residents with urinary incontinence were comprehensively reviewed to determine if a toileting program was appropriate to promote urinary continence. Care plans revised as necessary. All licensed nursing staff will be educated on necessary toileting program identification and implementation to promote urinary continence and individualized interventions to prevent complications and to provide skin protection and infection prevention. DON or designee will complete audit of residents to ensure comprehensive bladder assessment are completed, toileting program considered and implemented when indicated, and that resident care plan reflects current continence status with	06/09/2026

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F0690 SS = D	Continued from page 16 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and, if needed, develop a toileting program to promote urinary continence and reduce the risk of complication (i.e., skin infection, breakdown) for 1 of 3 residents (R2) reviewed. On 5/12/26 at 12:35 p.m., R2's family member (FM)-D was interviewed. R2 was admitted to the care center after being hospitalized for an extended period due to multiple conditions and he had used a catheter while in the hospital, but it was removed before he discharged to the care center on 4/13/26. FM-D stated R2 was "doing good" with using the bathroom and able to sense the need to go when he left the hospital. R2 also had some healing surgical incisions near his groin which were all intact and open-to-air (OTA). However, then they opened while at the care center and R2 had to eventually go back to the hospital due to them being re-opened and becoming infected. FM-D stated the family had visited at times and found R2 to be incontinent of urine which made them question if that contributed to the incisions becoming infected, adding, "Nursing 101 is keep the incision sites clean and dry." FM-D stated they were unsure if R2 ever attempted or was placed on a toileting plan while in the care center to help reduce the incontinence. R2's progress note, dated 4/13/26, identified R2 admitted to the care center and had several medical conditions including peripheral arterial disease (PAD), acute kidney injury, chronic kidney disease (CKD), and high blood pressure. R2 needed	F0690	Continued from page 16 individualized interventions. Audits will be completed three times a week for 6 weeks with any concerns being brought to the DON for immediate follow-up. Results will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	06/09/2026

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F0690 SS = D	Continued from page 17 assistance for all activities of daily living (ADLs), needed cues and reminders to ask for help, and was alert and oriented to self. The note identified R2 had been incontinent of urine and was unaware of such. Further, the note included a section labeled "Skin" that identified, " ... two healing surgical sites in bilateral groin ... Bruising to BUE [bilateral upper extremities] ... Small scabbed area to posterior calf on LLE [left lower extremity ... All areas OTA [open to air] and not draining. No redness, swelling, or warmth to peri-wounds." R2's Clinical Documentation (Admission), dated 4/13/26, identified a review of system completed upon admission. This identified R2 as needing supervision to complete a toileting transfer and partial/moderate assistance with toileting hygiene. The evaluation listed a section labeled "Bowel and Bladder" that identified R2 used no appliances, was frequently incontinent of urine and occasionally incontinent of bowel. There was no further assessment of R2's incontinence or dictation of what, if any, toileting program was needed, considered or attempted. R2's Bladder evaluation, dated 4/17/26, identified R2 used no appliances for elimination and was recorded as being frequently incontinent of urine. R2 was unable to recognize the appropriate time or place to urinate but was able to sense the urge to void. R2 had impaired mobility and severe cognitive impairment and was currently incontinent of bladder with his clothes being found wet. The evaluation listed multiple sections to be completed which included "Section 5 - Further Assessment" that had space to record a physical examination, a post-void residual (PVR), and if a urinalysis was performed, along with spacing to write the results. However, this section was left entirely blank and not completed. The section labeled "Section 6 - Incontinence Symptom Profile" had options to select which type of incontinence R2 was assessed to have present (i.e., urge, functional), however, this section was also left blank with nothing being selected or recorded. The section labeled "Section 7 - Summary of Program Placement Decision" identified R2 with functional incontinence, however, the remainder of the section, including spacing to record what toileting program was needed or if was not appropriate, was left blank and not completed. The evaluation concluded with summarized findings reading, "Resident incontinent of bladder. Does ask for urinal at times. Known to attempt urinal per self however not appropriately. Staff assist with incontinence cares." The evaluation was completed by licensed practical nurse (LPN)-C.	F0690		06/09/2026

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F0690 SS = D	Continued from page 18 R2's admission Minimum Data Set (MDS), dated 4/19/26, identified R2 admitted to the care center on 4/13/26 from the acute-care hospital. The MDS identified R2 had severe cognitive impairment and had surgical wounds present. Further, the MDS identified R2 used no elimination appliances (i.e., catheter) and was recorded as always incontinent of bowel and bladder; however, a toileting program had not been attempted since admission. R2's corresponding Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 4/21/26, identified R2 had no modifiable risk factors identified, demonstrated urinary urgency and needed assist with toileting, and demonstrated functional incontinence (i.e., can't get to toilet timely). The CAA identified, "CAA triggered due to resident is always incontinent of urine. Contributing factors include need for staff to assist with toileting. He is at risk for skin rashes, skin breakdown, and urinary infection. No referrals at this time. Will proceed to care plan to minimize risks." The CAA did not address if a toileting plan was considered, appropriate, or rationale why not to attempt one despite the incontinence and R2 being recorded as using the urinal at times. R2's Care Plan, dated 4/22/26, identified all the potential or actual problems R2 had along with goals and interventions to address them. This identified a section labeled "Category: Bowel & Bladder Function" that recorded R2 as having bladder and bowel incontinence along with interventions to address it including keeping the call light within reach, monitoring for signs of infection, providing R2 with the urinal/bedpan/commode as needed, and offering him toileting "frequently." This section of the care plan and its interventions were initiated on 4/20/26 (seven days after admission) and the plan lacked any further dictation or description of what "frequently" meant for his toileting. When interviewed on 5/12/26 at 1:24 p.m., nursing assistant (NA)-A stated they recalled working with R2. NA-A explained R2 needed help to use the bathroom and would, at times, refuse basic cares like getting cleaned up. NA-A stated they tried to help R2 with toileting every few hours or when he used the call light asking for the urinal. NA-A stated R2 was able to sense when he needed to void and would "off and on" use the call light to alert staff. NA-A stated they did not recall if R2 was on a formal toileting program or not but reiterated R2 would tell them if he needed to use the bathroom or not adding, "He usually told us."	F0690		06/09/2026

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F0690 SS = D	Continued from page 19 R2's medical record was reviewed and lacked evidence R2 had been comprehensively assessed for his bladder function and incontinence including to determine what, if any, toileting program may be beneficial for R2 since he was able to sense the need to void, could alert staff for assistance, and had active healing surgical wounds around his groin, which were at risk for infection. When interviewed on 5/12/26 1:27 p.m., LPN-C verified they completed the bladder evaluation for R2 (dated 4/17/26) and explained upon admission each resident has the Clinical Documentation evaluation completed and a Bladder evaluation completed after that. This should happen within the first seven (7) days after admission. LPN-C reviewed R2's completed Bladder evaluation and stated the section for a physical assessment (Section 5) was often not completed unless someone had a recent appliance removed or had pending lab results. LPN-C verified this was left blank on R2's evaluation (despite him using a catheter in the hospital for a period). The section for the incontinence profile (Section 6) was used to record the incontinence type and LPN-C verified the areas not completed and responded, "You're right." LPN-C stated they could have completed that section and there was "a missing aspect under that [section]." LPN-C stated the section for the toileting program determination (Section 7) was also left nearly blank and acknowledged no decision for a program adding, "You're right." LPN-C stated they were unsure why they didn't complete the evaluation and program selection adding, "I guess I can't answer that." LPN-C stated the center rarely used a three-day tracking diary or other tool to evaluate potential toileting programs, but the staff could check the recorded point-of-care (POC) responses if needed, but added, "I personally do, but can't speak for others." On 5/13/26 at 10:33 a.m., the director of nursing (DON) and administrator were interviewed. DON explained that the Bladder evaluation is completed after a few days from admission and the MDS nurses will then develop a care plan from that information and determine if a toileting program should be implemented with therapies (PT/OT) able to give input on that decision. DON stated the center didn't do a toileting program often, rather just did basic plans like assistance before meals, after meals, and as requested. DON stated the word "frequently" was a "very vague term" on the care plan. DON explained each section of the Bladder evaluation and stated they expected the sections left all or mostly blank on R2's evaluation (i.e., 5 - 7) to be	F0690		06/09/2026

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F0690 SS = D	Continued from page 20 completed. This was important to do as "it's a requirement" and helps staff to have a "clearer picture of the resident." DON acknowledged the record lacked evidence or rationale why this had not been done for R2. A facility policy on bladder evaluations was requested; however, none was received.	F0690		06/09/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure high-risk medications were provided timely after being ordered to help prevent potential blood clots for 1 of 1 resident (R1) reviewed. R1 had Eliquis (an	F0755	R1 is no longer a resident of the facility. All residents who have admitted or readmitted within the past 30 days with newly ordered anticoagulation medications were reviewed to ensure physician orders were transcribed accurately and initiated timely. Any concerns or discrepancies were communicated to the provider. All licensed nursing staff will be educated on timely implementation of anticoagulation medications and use/ availability of E-Kit medications. DON or designee will complete audit of resident orders to ensure timely implementation of anticoagulation medications and appropriate use of E-Kit when indicated. Audits will be completed three times a week for 6 weeks with any concerns being brought to the DON for immediate follow-up. Results will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	06/09/2026

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F0755 SS = D	Continued from page 21 anticoagulant, blood thinning, medication) ordered by the medical doctor (MD)-A on 4/10/26; however, this was not provided to R1 until 4/12/26 despite supply of the medication available in the emergency kit (E-Kit) onsite. R1's Hospitalist Discharge Summary, dated 4/1/26, identified R1 would be transitioned to the care center and listed a principal problem, "Acute cholecystitis (gallbladder inflammation)." R1's other active problems included high blood pressure, heart failure, and atrial fibrillation (irregular heart rhythm). R1 was described as a 93-year-old female who admitted to the hospital on 3/25/26 with acute cholecystitis and underwent surgery for this condition. R1 then developed atrial fibrillation with rapid ventricular rate (RVR). The summary outlined, "Eliquis on hold postoperatively." R1 discharged the hospital with a Jackson Pratt (JP) drain in place and would follow up in the general surgery clinic. The note added, "She will hold Eliquis until JP drain is removed." R1's corresponding After Discharge Orders, dated 4/1/26, identified R1's hospital discharge orders. These listed a section labeled, "Discharge Medications" that contained two medications listed under the heading, "PAUSE taking these medications." One of the medications listed under this heading identified the Eliquis and directions below, "Wait to take this until your doctor or other care provider tells you to start again. After JP [Jackson Pratt] drain is out." The orders included no other anticoagulant medications. R1's Progress Note, dated 4/6/26, identified R1 was seen by the general surgery service for post-operative follow up. The note identified the surgery was on 3/26/26, and the patient was "doing well" and the JP drain had not had output for "a few days." The JP drain was removed, and the site was reapproximated with Steri-Strips. The note identified sections below the dictation that read, "Orders Placed," and "Medication Changes," but these were both answered with text reading, "None." The note did not address R1's Eliquis, which remained on hold since she was admitted to the care center six days prior. R1's H&P (History & Physical), dated 4/10/26, identified R1 was seen by the medical doctor (MD)-A for a routine nursing home visit. The note recorded, "Since discharge she feels generally well and has no nausea. She has significant fatigue ... she notes an irregular heartbeat." The note listed a section labeled, "ASSESSMENT/PLAN," which reviewed each medical condition and subsequent orders for	F0755		06/09/2026

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F0755 SS = D	Continued from page 22 them. This included, "Atrial Fibrillation Paroxysmal (HCC)," and dictation which read, "Persistent with mildly elevated ventricular rate after recent sepsis hospitalization ... Apixaban [Eliquis] was to be restarted when JP drain was removed. I wrote that order today." R1's subsequent order, dated 4/10/26, identified directions which included taking Eliquis 2.5 mg orally twice a day. The order was signed by MD-A on 4/10/26 at 9:31 p.m., and the fax was time-stamped as received by the care center at 9:33 p.m. R1's Medication Administration Record (MAR), dated 4/2026, identified R1's administered medications for the month period. This included an order for Eliquis 2.5 mg twice a day with dates recorded, "04/11/2026 - 4/15/2026." The medication was recorded as not being administered on 4/11/26 for either dose with comments written, "Other ... pharmacy will deliver med ASAP," and "Drug/Item unavailable." R1's first recorded dose of the Eliquis was on 4/12/26 in the morning (AM) hours. R1's progress note, dated 4/15/26, identified the nursing assistant (NA) reported R1 sat on her bedside and was unable to move her left leg. The note recorded the leg, " ... appeared to be difference [sic] in color and cooler than right side ... resident said that she couldn't feel sensation on left foot. Called for ambulance and called daughter ... left via ambulance ...." When interviewed on 5/12/26 at 10:24 a.m., licensed practical nurse (LPN)-C reviewed R1's medical record and explained she was admitted to the care center following gallbladder surgery with a JP drain in place. LPN-C reviewed R1's Eliquis and stated the order to resume it was faxed to the center on 4/10/26 late in the evening and entered in the EMR to begin on 4/11/26. LPN-C acknowledged the doses on 4/11/26 were not administered and expressed they were unsure why it wasn't given as a supply of Eliquis was available in the onsite emergency kit (E-kit). LPN-C retrieved a black-colored binder that had the E-Kit supply listed and Eliquis was included. LPN-C then showed the surveyor the medication room which had an AlixaRx machine present. On the front of the machine, a white-colored paper was taped with the medications available. Eliquis was listed and the paper was dated, "4-Nov-24." Further, LPN-C stated Eliquis was considered a high-risk medication and not getting the medication resumed timely when ordered would be a concern adding aloud, "It's significant." On 5/12/26 at 1:59 p.m., unit nurse manager (RN)-B,	F0755		06/09/2026

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BENEDICTINE LIVING COMMUNITY OWATONNA	2255 30TH STREET NW , OWATONNA, Minnesota, 55060

(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
F0755 SS = D	Continued from page 23 the director of nursing (DON), and administrator were interviewed. DON explained the pharmacy sends medications to the campus once a day usually in the early morning hours, so an order received late at night wouldn't likely arrive the following day, however, the E-Kit was available and had some of that medication inside at the time on 4/11/26 to at least provide a dose. DON stated they would consider Eliquis to be a high-risk medication, and it should be given timely when ordered to help prevent blood clots. When interviewed on 5/12/26 at 2:32 p.m., MD-A stated they were the campus' medical director and reviewed R1's Eliquis. MD-A visited R1 on 4/10/26 and on that day learned it was to be restarted but were unsure if they identified that themselves or if the nurses at the center raised the issue with them. MD-A stated when they saw R1 on 4/10/26, there was no concern for a blood clot in her leg at that time, so the clotting most likely happened after that visit. MD-A stated if the medication was available in the E-Kit on 4/11/26 then a dose could have been removed and provided immediately following the order on 4/10/26 adding, "That would be a med I would administer sooner rather than later." On 5/12/26 at 3:23 p.m., the dispensing pharmacist (DP)-A was interviewed and verified their service distributed the medications to the campus. DP-A stated their current formulary showed Eliquis as being available in the campus E-Kit, but they would have to check and then send a review of the "retrospective inventory" after the interview to confirm a medication supply was available on 4/11/26. DP-A stated nurses were always able to call them and ask about medication supply if they had questions about it. DP-A stated Eliquis was a medication the patient should not be without for a long period and explained the "half-life" of the medication (the time it takes for the concentration of that drug in your body to reduce by exactly 50%) was about 12 hours, and the medication starts working within an hour of being given. If a patient went for several days without it, then the effects of the medication would likely be totally removed from the body systems. DP-A stated having a period of multiple days between an order and actual administration would make a difference with the risk of blood clots being formed adding, "It would matter something." An e-mail correspondence received from DP-A on 5/12/26 at 5:28 p.m., identified Eliquis was available with at least one dose in the E-Kit on 4/11/26. The email identified, "It appears that the facility had a	F0755		06/09/2026

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F0755 SS = D	Continued from page 24 balance on hand in their [kit] to initiate therapy before the cards were delivered." A provided Emergency Pharmacy Service and Emergency Kits policy, dated 12/2017, identified emergency pharmacy services were available on a 24-hour basis through the approved emergency medication supply. The supply was maintained in the ADU (automated dispensing unit) room along with a list of supply and expiration dates. The policy then listed a procedure to withdraw and use the medication and document it on the medical record.	F0755		06/09/2026

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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 5/12/26 to 5/13/26, a complaint survey was conducted at your facility by a surveyor 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 and identify the date when they will be completed. The following complaints were reviewed: H54262047C (3006067); order issued at 1550.	20000		05/28/2026

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

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20000	Continued from page 1 H54261699C (2996678); order issued at 0910. 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 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 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.	20000		05/28/2026
20910	Rehab - Incontinence CFR(s): MN Rule 4658.0525 Subp. 5 A.B Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the	20910		06/09/2026

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20910	Continued from page 2 resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and, if needed, develop a toileting program to promote urinary continence and reduce the risk of complication (i.e., skin infection, breakdown) for 1 of 3 residents (R2) reviewed. On 5/12/26 at 12:35 p.m., R2's family member (FM)-D was interviewed. R2 was admitted to the care center after being hospitalized for an extended period due to multiple conditions and he had used a catheter while in the hospital, but it was removed before he discharged to the care center on 4/13/26. FM-D stated R2 was "doing good" with using the bathroom and able to sense the need to go when he left the hospital. R2 also had some healing surgical incisions near his groin which were all intact and open-to-air (OTA). However, then they opened while at the care center and R2 had to eventually go back to the hospital due to them being re-opened and becoming infected. FM-D stated the family had visited at times and found R2 to be incontinent of urine which made them question if that contributed to the incisions becoming infected, adding, "Nursing 101 is keep the incision sites clean and dry." FM-D stated they were unsure if R2 ever attempted or was placed on a toileting plan while in the care center to help reduce the incontinence. R2's progress note, dated 4/13/26, identified R2 admitted to the care center and had several medical conditions including peripheral arterial disease (PAD), acute kidney injury, chronic kidney disease (CKD), and high blood pressure. R2 needed assistance for all activities of daily living (ADLs), needed cues and reminders to ask for help, and was alert and oriented to self. The note identified R2 had been incontinent of urine and was unaware of such. Further, the note included a section labeled "Skin" that identified, " ... two healing surgical sites in bilateral groin ... Bruising to BUE [bilateral upper extremities] ... Small scabbed area to posterior calf on LLE [left lower extremity ... All areas OTA [open to air] and not draining. No redness, swelling, or warmth to peri-wounds."	20910		06/09/2026

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20910	Continued from page 3 R2's Clinical Documentation (Admission), dated 4/13/26, identified a review of system completed upon admission. This identified R2 as needing supervision to complete a toileting transfer and partial/moderate assistance with toileting hygiene. The evaluation listed a section labeled "Bowel and Bladder" that identified R2 used no appliances, was frequently incontinent of urine and occasionally incontinent of bowel. There was no further assessment of R2's incontinence or dictation of what, if any, toileting program was needed, considered or attempted. R2's Bladder evaluation, dated 4/17/26, identified R2 used no appliances for elimination and was recorded as being frequently incontinent of urine. R2 was unable to recognize the appropriate time or place to urinate but was able to sense the urge to void. R2 had impaired mobility and severe cognitive impairment and was currently incontinent of bladder with his clothes being found wet. The evaluation listed multiple sections to be completed which included "Section 5 - Further Assessment" that had space to record a physical examination, a post-void residual (PVR), and if a urinalysis was performed, along with spacing to write the results. However, this section was left entirely blank and not completed. The section labeled "Section 6 - Incontinence Symptom Profile" had options to select which type of incontinence R2 was assessed to have present (i.e., urge, functional), however, this section was also left blank with nothing being selected or recorded. The section labeled "Section 7 - Summary of Program Placement Decision" identified R2 with functional incontinence, however, the remainder of the section, including spacing to record what toileting program was needed or if was not appropriate, was left blank and not completed. The evaluation concluded with summarized findings reading, "Resident incontinent of bladder. Does ask for urinal at times. Known to attempt urinal per self however not appropriately. Staff assist with incontinence cares." The evaluation was completed by licensed practical nurse (LPN)-C. R2's admission Minimum Data Set (MDS), dated 4/19/26, identified R2 admitted to the care center on 4/13/26 from the acute-care hospital. The MDS identified R2 had severe cognitive impairment and had surgical wounds present. Further, the MDS identified R2 used no elimination appliances (i.e., catheter) and was recorded as always incontinent of bowel and bladder; however, a toileting program had not been attempted since admission. R2's corresponding Urinary Incontinence and Indwelling	20910		06/09/2026

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20910	Continued from page 4 Catheter Care Area Assessment (CAA), dated 4/21/26, identified R2 had no modifiable risk factors identified, demonstrated urinary urgency and needed assist with toileting, and demonstrated functional incontinence (i.e., can't get to toilet timely). The CAA identified, "CAA triggered due to resident is always incontinent of urine. Contributing factors include need for staff to assist with toileting. He is at risk for skin rashes, skin breakdown, and urinary infection. No referrals at this time. Will proceed to care plan to minimize risks." The CAA did not address if a toileting plan was considered, appropriate, or rationale why not to attempt one despite the incontinence and R2 being recorded as using the urinal at times. R2's Care Plan, dated 4/22/26, identified all the potential or actual problems R2 had along with goals and interventions to address them. This identified a section labeled "Category: Bowel & Bladder Function" that recorded R2 as having bladder and bowel incontinence along with interventions to address it including keeping the call light within reach, monitoring for signs of infection, providing R2 with the urinal/bedpan/commode as needed, and offering him toileting "frequently." This section of the care plan and its interventions were initiated on 4/20/26 (seven days after admission) and the plan lacked any further dictation or description of what "frequently" meant for his toileting. When interviewed on 5/12/26 at 1:24 p.m., nursing assistant (NA)-A stated they recalled working with R2. NA-A explained R2 needed help to use the bathroom and would, at times, refuse basic cares like getting cleaned up. NA-A stated they tried to help R2 with toileting every few hours or when he used the call light asking for the urinal. NA-A stated R2 was able to sense when he needed to void and would "off and on" use the call light to alert staff. NA-A stated they did not recall if R2 was on a formal toileting program or not but reiterated R2 would tell them if he needed to use the bathroom or not adding, "He usually told us." R2's medical record was reviewed and lacked evidence R2 had been comprehensively assessed for his bladder function and incontinence including to determine what, if any, toileting program may be beneficial for R2 since he was able to sense the need to void, could alert staff for assistance, and had active healing surgical wounds around his groin, which were at risk for infection. When interviewed on 5/12/26 1:27 p.m., LPN-C verified they completed the bladder evaluation for R2	20910		06/09/2026

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20910	Continued from page 5 (dated 4/17/26) and explained upon admission each resident has the Clinical Documentation evaluation completed and a Bladder evaluation completed after that. This should happen within the first seven (7) days after admission. LPN-C reviewed R2's completed Bladder evaluation and stated the section for a physical assessment (Section 5) was often not completed unless someone had a recent appliance removed or had pending lab results. LPN-C verified this was left blank on R2's evaluation (despite him using a catheter in the hospital for a period). The section for the incontinence profile (Section 6) was used to record the incontinence type and LPN-C verified the areas not completed and responded, "You're right." LPN-C stated they could have completed that section and there was "a missing aspect under that [section]." LPN-C stated the section for the toileting program determination (Section 7) was also left nearly blank and acknowledged no decision for a program adding, "You're right." LPN-C stated they were unsure why they didn't complete the evaluation and program selection adding, "I guess I can't answer that." LPN-C stated the center rarely used a three-day tracking diary or other tool to evaluate potential toileting programs, but the staff could check the recorded point-of-care (POC) responses if needed, but added, "I personally do, but can't speak for others." On 5/13/26 at 10:33 a.m., the director of nursing (DON) and administrator were interviewed. DON explained that the Bladder evaluation is completed after a few days from admission and the MDS nurses will then develop a care plan from that information and determine if a toileting program should be implemented with therapies (PT/OT) able to give input on that decision. DON stated the center didn't do a toileting program often, rather just did basic plans like assistance before meals, after meals, and as requested. DON stated the word "frequently" was a "very vague term" on the care plan. DON explained each section of the Bladder evaluation and stated they expected the sections left all or mostly blank on R2's evaluation (i.e., 5 - 7) to be completed. This was important to do as "it's a requirement" and helps staff to have a "clearer picture of the resident." DON acknowledged the record lacked evidence or rationale why this had not been done for R2. A facility policy on bladder evaluations was requested; however, none was received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review	20910		06/09/2026

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20910	Continued from page 6 applicable policies on comprehensive bladder assessments and care planning and educate floor staff, then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	20910		06/09/2026
21550	Adminiatration of Medications; Pharmacy Serv. CFR(s): MN Rule 4658.1325 Subp. 1 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure high-risk medications were provided timely after being ordered to help prevent potential blood clots for 1 of 1 resident (R1) reviewed. R1 had Eliquis (an anticoagulant, blood thinning, medication) ordered by the medical doctor (MD)-A on 4/10/26; however, this was not provided to R1 until 4/12/26 despite supply of the medication available in the emergency kit (E-Kit) onsite. R1's Hospitalist Discharge Summary, dated 4/1/26, identified R1 would be transitioned to the care center and listed a principal problem, "Acute cholecystitis (gallbladder inflammation)." R1's other active problems included high blood pressure, heart failure, and atrial fibrillation (irregular heart rhythm). R1 was described as a 93-year-old female who admitted to the hospital on 3/25/26 with acute cholecystitis and underwent surgery for this condition. R1 then developed atrial fibrillation with rapid ventricular rate (RVR). The summary outlined, "Eliquis on hold postoperatively." R1 discharged the hospital with a Jackson Pratt (JP) drain in place and would follow up in the general surgery clinic. The note added, "She will hold Eliquis until JP drain is removed." R1's corresponding After Discharge Orders, dated 4/1/26, identified R1's hospital discharge orders. These listed a section labeled, "Discharge Medications" that contained two medications listed under the heading, "PAUSE taking these medications." One of the medications listed under this heading identified the Eliquis and directions below, "Wait to take this until your doctor or other care provider tells you to start again. After JP [Jackson Pratt] drain is out." The orders included no other anticoagulant medications.	21550		06/09/2026

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21550	Continued from page 7 R1's Progress Note, dated 4/6/26, identified R1 was seen by the general surgery service for post-operative follow up. The note identified the surgery was on 3/26/26, and the patient was "doing well" and the JP drain had not had output for "a few days." The JP drain was removed, and the site was reapproximated with Steri-Strips. The note identified sections below the dictation that read, "Orders Placed," and "Medication Changes," but these were both answered with text reading, "None." The note did not address R1's Eliquis, which remained on hold since she was admitted to the care center six days prior. R1's H&P (History & Physical), dated 4/10/26, identified R1 was seen by the medical doctor (MD)-A for a routine nursing home visit. The note recorded, "Since discharge she feels generally well and has no nausea. She has significant fatigue ... she notes an irregular heartbeat." The note listed a section labeled, "ASSESSMENT/PLAN," which reviewed each medical condition and subsequent orders for them. This included, "Atrial Fibrillation Paroxysmal (HCC)," and dictation which read, "Persistent with mildly elevated ventricular rate after recent sepsis hospitalization ... Apixaban [Eliquis] was to be restarted when JP drain was removed. I wrote that order today." R1's subsequent order, dated 4/10/26, identified directions which included taking Eliquis 2.5 mg orally twice a day. The order was signed by MD-A on 4/10/26 at 9:31 p.m., and the fax was time-stamped as received by the care center at 9:33 p.m. R1's Medication Administration Record (MAR), dated 4/2026, identified R1's administered medications for the month period. This included an order for Eliquis 2.5 mg twice a day with dates recorded, "04/11/2026 - 4/15/2026." The medication was recorded as not being administered on 4/11/26 for either dose with comments written, "Other ... pharmacy will deliver med ASAP," and "Drug/Item unavailable." R1's first recorded dose of the Eliquis was on 4/12/26 in the morning (AM) hours. R1's progress note, dated 4/15/26, identified the nursing assistant (NA) reported R1 sat on her bedside and was unable to move her left leg. The note recorded the leg, " ... appeared to be difference [sic] in color and cooler than right side ... resident said that she couldn't feel sensation on left foot. Called for ambulance and called daughter ... left via ambulance ...." When interviewed on 5/12/26 at 10:24 a.m., licensed practical nurse (LPN)-C reviewed R1's medical	21550		06/09/2026

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21550	Continued from page 8 record and explained she was admitted to the care center following gallbladder surgery with a JP drain in place. LPN-C reviewed R1's Eliquis and stated the order to resume it was faxed to the center on 4/10/26 late in the evening and entered in the EMR to begin on 4/11/26. LPN-C acknowledged the doses on 4/11/26 were not administered and expressed they were unsure why it wasn't given as a supply of Eliquis was available in the onsite emergency kit (E-kit). LPN-C retrieved a black-colored binder that had the E-Kit supply listed and Eliquis was included. LPN-C then showed the surveyor the medication room which had an AlixaRx machine present. On the front of the machine, a white-colored paper was taped with the medications available. Eliquis was listed and the paper was dated, "4-Nov-24." Further, LPN-C stated Eliquis was considered a high-risk medication and not getting the medication resumed timely when ordered would be a concern adding aloud, "It's significant." On 5/12/26 at 1:59 p.m., unit nurse manager (RN)-B, the director of nursing (DON), and administrator were interviewed. DON explained the pharmacy sends medications to the campus once a day usually in the early morning hours, so an order received late at night wouldn't likely arrive the following day, however, the E-Kit was available and had some of that medication inside at the time on 4/11/26 to at least provide a dose. DON stated they would consider Eliquis to be a high-risk medication, and it should be given timely when ordered to help prevent blood clots. When interviewed on 5/12/26 at 2:32 p.m., MD-A stated they were the campus' medical director and reviewed R1's Eliquis. MD-A visited R1 on 4/10/26 and on that day learned it was to be restarted but were unsure if they identified that themselves or if the nurses at the center raised the issue with them. MD-A stated when they saw R1 on 4/10/26, there was no concern for a blood clot in her leg at that time, so the clotting most likely happened after that visit. MD-A stated if the medication was available in the E-Kit on 4/11/26 then a dose could have been removed and provided immediately following the order on 4/10/26 adding, "That would be a med I would administer sooner rather than later." On 5/12/26 at 3:23 p.m., the dispensing pharmacist (DP)-A was interviewed and verified their service distributed the medications to the campus. DP-A stated their current formulary showed Eliquis as being available in the campus E-Kit, but they would have to check and then send a review of the "retrospective inventory" after the interview to	21550		06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/13/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21550	Continued from page 9 confirm a medication supply was available on 4/11/26. DP-A stated nurses were always able to call them and ask about medication supply if they had questions about it. DP-A stated Eliquis was a medication the patient should not be without for a long period and explained the "half-life" of the medication (the time it takes for the concentration of that drug in your body to reduce by exactly 50%) was about 12 hours, and the medication starts working within an hour of being given. If a patient went for several days without it, then the effects of the medication would likely be totally removed from the body systems. DP-A stated having a period of multiple days between an order and actual administration would make a difference with the risk of blood clots being formed adding, "It would matter something." An e-mail correspondence received from DP-A on 5/12/26 at 5:28 p.m., identified Eliquis was available with at least one dose in the E-Kit on 4/11/26. The email identified, "It appears that the facility had a balance on hand in their [kit] to initiate therapy before the cards were delivered." A provided Emergency Pharmacy Service and Emergency Kits policy, dated 12/2017, identified emergency pharmacy services were available on a 24-hour basis through the approved emergency medication supply. The supply was maintained in the ADU (automated dispensing unit) room along with a list of supply and expiration dates. The policy then listed a procedure to withdraw and use the medication and document it on the medical record. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies on emergency medication use from the onsite emergency kit (E-Kit) and educate floor staff, then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21550		06/09/2026

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F0000	INITIAL COMMENTS On 5/12/26 to 5/13/26, an abbreviated survey was completed by a surveyor from the Minnesota Department of Health (MDH) to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, the Requirements for Long Term Care Facilities. The following complaints were reviewed: H54262047C (3006067); with non-compliance cited at F684, F755. H54261699C (2996678); with non-compliance cited at F655, F684, F690. 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		
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to educate on risk and	F0684	R1 and R2 no longer reside in the facility. All facility residents with orders for anticoagulation medications, compression wraps, and surgical incisions/wounds were reviewed to ensure orders and active monitoring were in place to prevent the risk of clotting and deep vein thrombosis (DVT). All residents will be reviewed in daily facility IDT meeting to ensure comprehensive clinical review of hospital discharge documentation, physician orders, anticoagulation therapy, compression therapy orders, and post-surgical monitoring requirements. All licensed nursing staff will receive education on the following: Risk and prevention of deep vein	06/09/2026

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.

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

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F0684 SS = G	Continued from page 1 prevention of deep vein thrombosis (DVT); failed to ensure applied compression wraps for DVT prevention were clarified upon admission for ongoing use; and failed to ensure physician orders for resumption of anticoagulant (blood thinning) medication were acted upon timely to help reduce the clotting risk for 1 of 3 residents (R1) reviewed. R1 was subsequently hospitalized and died due to severe blood clotting with an ischemic (insufficient blood flow) leg and pulmonary embolism (clot in the lung) resulting in actual harm for R1. In addition, the facility failed to ensure surgical incisions were adequately monitored by nursing staff to reduce the risk of complication (i.e., delayed response to infection) for 1 of 3 residents (R2) reviewed who had surgical wounds. Findings include: R1: R1's Hospitalist Discharge Summary, dated 4/1/26, identified R1 would be transitioned to the care center and listed a principal problem of acute cholecystitis (gallbladder inflammation). R1's other active problems included high blood pressure, heart failure, and atrial fibrillation (irregular heart rhythm). R1 was described as a 93-year-old female who admitted to the hospital on 3/25/26 with acute cholecystitis and underwent surgery for this condition. R1 then developed atrial fibrillation with rapid ventricular rate (RVR). The summary outlined, "Eliquis (anticoagulant – blood thinner) on hold postoperatively." R1 discharged the hospital with a Jackson Pratt (JP) drain (a tube placed into a wound to allow drainage of fluid) in place and would follow up in the general surgery clinic. The note added, "She will hold Eliquis until JP drain is removed." R1's corresponding After Discharge Orders, dated 4/1/26, identified R1's hospital discharge orders. These listed a section labeled, "Discharge Medications" that contained two medications listed under the heading, "PAUSE taking these medications." One of the medications listed under this heading was Eliquis 2.5 milligrams (mg) with directions below, "Wait to take this until your doctor or other care provider tells you to start again. After JP [Jackson Pratt] drain is out." The orders included no other anticoagulant medications or directions for compression wraps to be applied. R1's progress note, dated 4/1/26, identified R1 admitted to the care center, and she was alert and oriented. R1 had multiple medical conditions including atrial fibrillation and she had a JP drain in	F0684	Continued from page 1 thrombosis (DVT), compression wraps, resumption of anticoagulation (blood thinning) medication management, timely implementation of physician orders (POL_NS901), medication reconciliation, and surgical incision monitoring. DON or designee will complete audit of resident orders to ensure medication reconciliation is completed, anticoagulant orders are accurately transcribed and implemented, compression therapy orders are verified and implemented and surgical incisions are adequately monitored. Audits will be completed three times a week for 6 weeks with any concerns being brought to the DON for immediate follow-up. Results will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review if substantial compliance is not met.	06/09/2026

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F0684 SS = G	Continued from page 2 place with bloody drainage present. The note recorded, "No edema. Wearing compression socks. HR [heart rate] irregular." R1's vital signs were stable on one liter of oxygen (O2). Licensed practical nurse (LPN)-C authored the note. A subsequent note, dated 4/1/26, identified R1 was seen by physical therapy (PT) and initial evaluations were completed. The note recorded, "Assist of 2 pivot transfers. Assist of 2 toileting and self-cares." R1's progress note, dated 4/3/26, identified R1 was seen by occupational therapy (OT) and identified, "Transfers: 1A [one assist] pivot w/ 4WW [walker] ... Self Cares: Extensive assist ... Toileting: 1A pivot w/ grab bars." R1's Progress Note, dated 4/6/26, identified R1 was seen by the general surgery service for post-operative follow-up. The note identified the surgery was on 3/26/26, and the patient was "doing well" and the JP drain had not had output for "a few days." The JP drain was removed, and the site was reapproximated with Steri-Strips. The note recorded, "[R1] is doing well postoperatively ... At this point the patient is dismissed from our surgical service." The note identified sections below the dictation which read, "Orders Placed," and "Medication Changes," but these were both answered with text reading, "None." The note did not address R1's Eliquis, which remained on hold since she was admitted to the care center six days prior. R1's admission Minimum Data Set (MDS), dated 4/7/26, identified R1 had intact cognition along with several medical conditions including heart failure and atrial fibrillation. The MDS identified R1's consumed medications during the evaluation period, where the space to record anticoagulant consumption was left un-checked (i.e., not administered). R1's progress note, dated 4/8/26, identified R1 was seen by therapy and was now an assist of one for walking to and from the bathroom with a gait belt and walker. The note identified, "[R1] is to walk 3x day with a [walker] and 1 A with gait belt and [wheelchair] follow." R1's H&P (History & Physical), dated 4/10/26, identified R1 was seen by the medical doctor (MD)-A for a routine nursing home visit due to admission. R1 had been recently hospitalized for sepsis (life-threatening response to infection) due to acute cholecystitis and had surgery. R1 developed atrial fibrillation with RVR post-operatively and was discharged to the care center on 4/1/26 with a JP	F0684		06/09/2026

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F0684 SS = G	Continued from page 3 drain in place. The note recorded, "Since discharge she feels generally well and has no nausea. She has significant fatigue ... she notes an irregular heartbeat." MD-A completed a physical examination of R1 which outlined, "Extremities: Normal without edema." The note listed a section labeled, "ASSESSMENT/PLAN" that reviewed each medical condition and subsequent orders for them. This included, "Atrial Fibrillation Paroxysmal (HCC)," and dictation that read, "Persistent with mildly elevated ventricular rate after recent sepsis hospitalization ... Apixaban [Eliquis] was to be restarted when JP drain was removed. I wrote that order today." R1's subsequent order, dated 4/10/26, identified directions which included taking Eliquis 2.5 mg orally twice a day. The order was signed by MD-A on 4/10/26 (four days after the JP drain was removed) at 9:31 p.m., and the fax was time-stamped it was received by the care center at 9:33 p.m. R1's Medication Administration Record (MAR), dated 4/2026, identified R1's administered medications for the month period. This included an order for Eliquis 2.5 mg twice a day with dates recorded, "04/11/2026 - 4/15/2026." The medication was recorded as not being administered on 4/11/26 for either dose with comments written, "Other ... pharmacy will deliver med ASAP," and "Drug/Item unavailable." R1's first recorded dose of the Eliquis was on 4/12/26 (two days after being ordered) in the morning hours. The medication was provided until 4/14/26 (evening) and the space to record the morning dose on 4/15/26 was left blank with nothing identified. Further, R1's Treatment Administration Record (TAR) lacked any evidence of use of compression wraps or TEDs despite R1 admitting from the hospital with them on. R1's medical record lacked evidence R1 had been educated on DVT prevention including potential exercises R1 could do on her own while in bed to help prevent blood clots (i.e., ankle pumps); it lacked evidence R1's compression wraps, which were present on her upon admission, were clarified with the provider to determine if these should continue given R1 being off her anticoagulant medication and being at increased risk of blood clot; and lacked evidence of any shift-to-shift nursing monitoring (i.e., calf measurements, leg pain, skin discolorations) for a potential blood clot despite R1 being off her anticoagulant medication. Further, the record lacked evidence that the care center had acted upon the hospital's discharge order and notified the physician to resume the Eliquis when the JP drain was removed prior to 4/10/26, despite the drain being removed on 4/6/26 (four days	F0684		06/09/2026

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F0684 SS = G	Continued from page 4 earlier). R1's progress note, dated 4/15/26, identified the nursing assistant (NA) reported R1 sat on her bedside and was unable to move her left leg. The note recorded the leg, " ... appeared to be difference [sic] in color and cooler than right side ... resident said that she couldn't feel sensation on left foot. Called for ambulance and called daughter ... left via ambulance ...." R1's Emergency Department (ED) Encounter, dated 4/15/26, identified R1 presented with decreased sensation in her left leg with the leg being, "cool and dusky with a visible color change. Unable to Doppler pulses extending up to the popliteal. [back of the knee]" The note identified a CT was completed which identified an acute pulmonary embolism [blood clot in the lung] and near complete occlusion of the entire left iliofemoral and femoropopliteal system. The note identified when R1 arrived at the acute care hospital ED, she was having pain in her left hip that was, " ... still severe at 10/10." R1 was given heparin (an anticoagulant) via IV in the ED and the note identified, "She is being treated with heparin and will be sent to the OR emergently with vascular surgery for femoral cutdown, thrombectomy, [removal of blood clots], and likely fasciotomies [removal of facia] given the degree of ischemia. [death of tissue]. Both Dr. [name] from vascular surgery and I did impress upon the patient and her family the gravity of the situation and that she may well die in surgery but would almost certainly die without it." R1 agreed to the operation. On 5/11/26 at 1:21 p.m., R1's family member (FM)-A was interviewed. They explained that R1 was admitted to the care center following a hospitalization for gallbladder surgery and was not considered to be in terminal condition during the hospitalization or while admitted to the care center. R1 planned to return home to their assisted living facility (ALF) when they completed rehabilitation therapy at the care center. FM-A explained R1 had been on Eliquis prior to the hospitalization but it was held for her surgery and R1 discharged from the hospital to the nursing home with orders to resume the medication from their understanding. However, some issue happened that caused R1 to go for "almost two weeks" without the medication. FM-A stated their other family member had learned the medication was re-started on 4/11/26, when they started asking staff some questions about the medication. Then on 4/15/26, R1 developed a blood clot and had to be taken to the hospital where a	F0684		06/09/2026

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F0684 SS = G	Continued from page 5 "significant clot" was found. FM-A stated R1 must have been off the medication "a fatal amount of time" as the clot, which happened on 4/15/26, caused R1 to be hospitalized and R1 then passed away while in the hospital. FM-A stated watching R1 having pain and ultimately dying in the hospital was "a very sad thing to experience" and reiterated R1 planned to return to their ALF after the care center, until this medication incident happened. When interviewed on 5/12/26 at 10:17 a.m., nursing assistant (NA)-A stated they recalled working with R1 who needed minimal assistance with most cares. NA-A stated they could not recall R1 using compression wraps or TEDs while at the care center adding, "I'm not sure on that." NA-A stated R1 ambulated using a walker but not when she first admitted to the care center, adding the ambulation was "more at the end" before she was hospitalized. NA-A stated they heard R1 had developed a blood clot and had to be hospitalized but was unsure of the details around it. When interviewed on 5/12/26 at 10:24 a.m., licensed practical nurse (LPN)-C reviewed R1's medical record and explained she was admitted to the care center following gallbladder surgery with a JP drain in place. LPN-C stated compression wraps or TEDs would need a physician order for use and R1 didn't have them ordered upon admission. LPN-C reviewed the progress note they authored (dated 4/1/26), which identified R1 had them physically on when she admitted, and verified the record lacked evidence using them had been clarified with the physician. LPN-C adding that it "should be a group" of people who could have acted on that. LPN-C stated they did not recall R1 using compression wraps or TEDs while at the care center after she admitted and stated, "It was not followed up on." LPN-C stated monitoring for a potential blood clot would likely be charted in the "Medicare charting" progress notes, however, R1's note template did not have that listed as something to monitor. LPN-C stated if a medication, like Eliquis, was on hold from the hospital then the floor staff wouldn't always know that information, adding unless the person was here for a hip fracture or something of that nature, then staff would likely not be alert to a potential clot risk like R1 had. When questioned about who was responsible for assigning or developing the shift-to-shift monitoring notes, LPN-C stated the health unit coordinator (HUC) used to read the hospital notes and help suggest or implement some monitoring, but the position had been "patching together" for several weeks due to leaves and resignations. LPN-C then reviewed R1's Eliquis and	F0684		06/09/2026

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F0684 SS = G	Continued from page 6 stated the order to resume it was faxed to the center on 4/10/26 late in the evening and entered in the EMR to begin on 4/11/26. LPN-C acknowledged the doses on 4/11/26 were not administered and said they were unsure why it wasn't given, as a supply of Eliquis was available in the onsite emergency kit (E-kit). LPN-C stated they were unsure why there had been a delay of multiple days after the JP drain was removed, to when the Eliquis was restarted. LPN-C stated it was likely missed as the order to resume it had not been entered into the EMR for staff to ask about it: "We [floor staff] may never have known her Eliquis was on hold if we didn't look at the actual hospital summary." LPN-C stated not entering the orders on hold upon admission caused things "to be left to chance sometimes." LPN-C stated they felt all orders, including medications on hold, should be entered into the EMR so the floor staff were aware of them, adding, "The more information we have, the better." Further, LPN-C stated Eliquis was considered a high-risk medication and not getting the medication resumed for multiple days which caused missed doses, would be a concern, adding aloud, "It's significant." When interviewed on 5/12/26 at 11:23 a.m., registered nurse (RN)-A explained that when someone admitted from the hospital the HUC would take the information and enter it into the EMR. Then nurse would then verify it: "If I have time." RN-A stated if someone admitted with an order to hold Eliquis until a drain was removed, then they would place a general note in the EMR such as "an FYI-type thing." RN-A stated the need to resume it should be posted somewhere in the EMR for the floor staff to see repeatedly otherwise the order was likely to be missed. RN-A stated entering the order was not necessarily the policy of the campus but rather "something I would do." RN-A stated if someone admitted to the care center with compression wraps on but no order for them, it should be clarified right away. RN-A stated the shift-to-shift monitoring for each resident was determined by either the HUC or the floor nurse and entered into the system using the progress notes. RN-A stated they personally tried to review hospital notes on the residents, but not every nurse does that, adding some "newer nurses" seem to be very focused on the orders only and not looking at the whole situation of the resident. On 5/12/26 at 1:59 p.m., unit nurse manager (RN)-B, the director of nursing (DON), and administrator were interviewed. DON stated someone using an anticoagulant medication would more likely be monitored for bleeding risk and they would typically	F0684		06/09/2026

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F0684 SS = G	Continued from page 7 need "at least a provider recommendation" to monitor for clots before that would be entered and tracked in the EMR. DON reiterated none of the hospital discharge paperwork or subsequent physician notes directed to monitor for potential blood clots. However, DON stated if nursing had concerns about it then they could initiate a nursing order and update the medical provider. RN-B stated there was no order for compression wraps from the hospital when R1 admitted and felt maybe they were not needed anymore, adding it was "hard for me to say" if someone ever clarified it or not with the provider. DON stated if there were questions about the wraps being used or not, then someone could have reached out to the provider and clarified it. RN-B and DON also verified they were unable to locate any documentation to show R1 had been educated on the risk of blood clots and steps to reduce them. DON then reviewed R1's Eliquis and explained it wasn't an "active order" when she admitted on 4/1/26 so it would not have been entered into the EMR as it could cause a medication error. DON stated in R1's scenario that "multiple people" could have caught the order to resume it once the JP drain was removed including the medical provider who physically removed the drain itself, but they never addressed it in their note. DON stated the person who reviewed the notes on admission would be "the system" to catch this and resume the medication. When asked how it would be handled if that person was not working or resigned in the meantime, the DON replied, "I don't know if we have a fool-proof system in place for that," and suggested maybe using a "sticky note" on the desk in the office. DON verified there was no system outside of the EMR in place to ensure orders like R1's were identified and acted upon timely. DON explained the pharmacy sends medications to the campus once a day usually in the early morning hours, so an order received late at night wouldn't likely arrive the following day, however, the E-Kit was available and had some of that medication inside at the time on 4/11/26 to at least provide a dose. DON stated they would consider Eliquis to be a high-risk medication, and it should be given timely when ordered to help prevent blood clots. The DON and RN-B both acknowledged room to improve the communication surrounding this incident with R1 and the administrator expressed they felt the medical provider should have a responsibility to review medications after surgery adding they were unsure why the provider on 4/6/26 didn't address the medication then. When interviewed on 5/12/26 at 2:32 p.m., MD-A stated they were the campus' medical director and	F0684		06/09/2026

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F0684 SS = G	Continued from page 8 verified they had physically seen R1on 4/10/26 for the visit. MD-A stated they did not recall if anyone from the care center had clarified the compression wraps with them or not and expressed an order for their use was typically needed. MD-A stated either them or the nurses could catch that and have clarified it when R1 was admitted. MD-A stated use of compression wraps or TEDs was an intervention to help prevent blood clots in the legs and clarifying the order for R1 on 4/1/26 would have "[been] a reasonable thing to do." MD-A stated they did not recall providing any education to R1 on the prevention of blood clots, either. MD-A reviewed R1's Eliquis and stated they learned it was to be restarted on 4/10/26 when the visit happened but were unsure if they identified that themselves or if the nurses at the center raised the issue with them. MD-A stated when they saw R1 on 4/10/26, there was no concern for a blood clot in her leg at that time, so the clotting most likely happened after that visit. MD-A stated if R1 had her Eliquis restarted immediately after the JP drain was removed (on 4/6/26) it was "hard to say," if a clot and subsequent hospitalization could have been avoided but MD-A added, "Its possible it may have changed the outcome." MD-A stated if the medication was available in the E-Kit then a dose could have been removed and provided immediately following the order on 4/11/26 adding, "That would be a med I would administer sooner rather than later." MD-A stated it was "hard to say" if they expected to be notified by the nurses on 4/6/26 when the JP drain was removed but added that given the situation with R1 and what happened with her developing a clot it would have been "a great loop closure" to have been notified. MD-A expressed, "The takeaway [from this] is to identify loops that need to be closed and figure out the best process for doing that." MD-A stated, in hindsight, the nurses could have notified their service about the Eliquis adding, "That would have been nice, but it didn't happen." On 5/12/26 at 3:23 p.m., the dispensing pharmacist (DP)-A was interviewed and verified their service distributed the medications to the campus. DP-A stated their current formulary showed Eliquis as being available in the campus E-Kit, but they would have to check and then send a review of the "retrospective inventory" after the interview to confirm a medication supply was available on 4/11/26. DP-A stated nurses were always able to call them and ask about medication supply if they had questions about it. DP-A stated Eliquis was a medication the patient should not be without for a long period and explained the "half-life" of the medication (the time it takes for the concentration of	F0684		06/09/2026

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F0684 SS = G	Continued from page 9 that drug in your body to reduce by exactly 50%) was about 12 hours, and the medication starts working within an hour of being given. If a patient went for several days without it, then the effects of the medication would likely be totally removed from the body systems. DP-A stated having a period of multiple days unnecessarily going without the medication would make a difference with the risk of blood clots being formed adding, "It would matter something." When interviewed on 5/12/26 at 4:05 p.m., the director of therapy (DOT) stated they were not the primary therapist who worked with R1 while she was at the care center, however, was somewhat familiar with her care and services she received. DOT stated the therapist chart in their own system, and they had reviewed the notes for R1, which identified R1 as not very mobile when she first admitted but then was "progressing really well" until she discharged to the hospital. DOT verified they were unable to locate any documentation to show R1 had been educated on the risk of blood clots and subsequent prevention techniques she could do on her own such as "ankle pumps." DOT also was unable to locate any information on R1's use of compression wraps while at the care center and stated the nurses were able to facilitate those if desired or needed. DOT stated they felt the education on DVT prevention was typically provided, however, there was nothing documented for R1 to show it had happened. An e-mail correspondence received from DP-A on 5/12/26 at 5:28 p.m., identified Eliquis was available with at least one dose in the E-Kit on 4/11/26. The email identified, "It appears that the facility had a balance on hand in their [kit] to initiate therapy before the cards were delivered." A provided Physician Services policy, dated 1/2019, identified the care center would provide services related to physician services in accordance with State and Federal regulations. This included a procedure which directed, "All physician orders will be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record during that shift." R2: On 5/12/26 at 12:35 p.m., R2's family member (FM)-D was interviewed. R2 was admitted to the care center after being hospitalized for an extended period due to multiple conditions and he had used a catheter while in the hospital, but it was removed	F0684		06/09/2026

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F0684 SS = G	Continued from page 10 before he discharged to the care center on 4/13/26. FM-D stated R2 was "doing good" with using the bathroom and able to sense the need to go when he left the hospital. R2 also had some healing surgical incisions near his groin which were all intact and open-to-air (OTA). However, then they opened while at the care center and R2 had to eventually go back to the hospital due to them being re-opened and becoming infected. FM-D questioned what wound cares had been provided and how these closed, healing wounds could have re-opened. R2's progress note, dated 4/13/26, identified R2 admitted to the care center and had several medical conditions including peripheral arterial disease (PAD), acute kidney injury, chronic kidney disease (CKD), and high blood pressure. R2 needed assistance for all activities of daily living (ADLs), needed cues and reminders to ask for help, and was alert and oriented to self. The note identified R2 had been incontinent of urine and was unaware of such. Further, the note included a section labeled, "Skin," which identified, " ... two healing surgical sites in bilateral groin ... Bruising to BUE [bilateral upper extremities] ... Small scabbed area to posterior calf on LLE [left lower extremity ... All areas OTA [open to air] and not draining. No redness, swelling, or warmth to peri-wounds." R2's Care Plan, dated 4/22/26, identified all the potential or actual problems R2 had along with goals and interventions to address them. This identified a section labeled, "Category: Bowel & Bladder Function," which recorded R2 as having bladder and bowel incontinence along with interventions to address it including keeping the call light within reach, monitoring for signs of infection, providing R2 with the urinal/bedpan/commode as needed, and offering him toileting frequently. The care plan continued and listed a section labeled, "Category: Pressure Ulcer/Injury," which recorded R2 as admitting with multiple surgical incisions and being at risk of skin breakdown. The plan listed several interventions including monitoring the skin, being involved in the treatment process, and applying barrier creams if needed. R2's medical record, including progress notes and treatment records, lacked evidence of any ongoing or shift-to-shift monitoring of R2's healing surgical wounds from 4/14/26 to 4/19/26. There was no evidence they were being observed by the nurses for symptoms of infection or potential dehiscence (surgical complication where a closed wound or incision ruptures and opens). In addition, R2's Wound Management section of the electronic	F0684		06/09/2026

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F0684 SS = G	Continued from page 11 medical record (EMR) lacked any evidence the surgical incisions were being tracked or monitored. R2's progress note, dated 4/19/26, identified R2 refused morning cares and his bedding was soiled. The nurse responded and assisted R2 into the bathroom and completed a body audit. The note identified, "Writer observed right inguinal/groin with full thickness wound measuring 1.7 cm [centimeters] X 1.9 cm. Large nodule purple in color right inguinal/groin inferior to wound measuring 5 cm X 7 cm." The left groin incision was recorded as well approximated and R2's vital signs were stable. A subsequent note, dated 4/19/26, identified an SBAR (acute situation update) note was faxed to the hospital and R2's family was updated, " ... of concern of incisions." When interviewed on 5/12/26 at 1:24 p.m., nursing assistant (NA)-A stated they recalled working with R2. NA-A explained R2 needed help to use the bathroom and would, at times, refuse basic care like getting cleaned up. NA-A stated they recalled trying to reposition R2 every few hours and were unsure if he ever had skin issues or wounds adding, "I don't remember that." When interviewed on 5/12/26 at 1:27 p.m., licensed practical nurse (LPN)-C stated if someone admitted with surgical wounds then they'd have daily monitoring done when the incision dressing was changed. If the wounds were open to air, such as R2's were, then the monitoring would be done and recorded on the "Medicare charting" notes in the progress notes or on the TAR. LPN-C stated there should be an order for monitoring with any surgical incision for "at least daily [checks]." LPN-C reviewed R2's medical record and acknowledged it lacked evidence of any ongoing monitoring of the surgical incisions from 4/14/26 to 4/19/26. LPN-C stated it was important to ensure incisions, even if closed and healing, were monitored until the wound was completely resolved. LPN-C stated they saw R2's incision on 4/19/26 when it had re-opened and completed the SBAR update to the physician. LPN-C stated they were unsure what had happened or caused it to open, but R2 ended up going to the hospital a few days later to have it addressed. On 5/13/26 at 10:33 a.m., the director of nursing (DON) and administrator were interviewed. DON explained a skin observation is completed upon admission and wounds or incisions should be recorded on that evaluation. If a surgical incision was present, which was draining or had concerning presentation, then the nurses could contact the	F0684		06/09/2026

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F0684 SS = G	Continued from page 12 medical provider or onsite wound nurse to review it. DON stated the NA staff were taught to observe the skin each day with cares and felt they'd report issues if seen. DON stated the Medicare charting is determined by the MDS nurses and not everyone would get incisional monitoring included, especially if the incisions were open to air like R2's were upon admission. DON verified they were unable to locate documentation to show any monitoring of the incisions from 4/14/26 to 4/19/26 and reiterated the NA staff were taught to check the skin with daily care. A provided Prevention and Treatment of Skin Breakdown policy, dated 9/2018, identified resident skin was assessed upon admission and weekly thereafter. A resident who was at increased risk for breakdown would be provided preventative measures to reduce the potential risk of skin breakdown. A procedure was listed that outlined steps to be completed which included, "Skin is observed daily with cares. If any skin concerns are noted, they are reported to the licensed nurse." The procedure then shifted to more pressure ulcer prevention and care and lacked any specific guidance or process for surgical incision monitoring.	F0684		06/09/2026
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders.	F0655	R2 is no longer a resident in the facility. All residents admitted to the facility within the past 30 days were reviewed to ensure a baseline care plan had been developed. All licensed nursing staff will be re-educated on Comprehensive Assessments and Care Planning (POL_NS101); specifically, the development of a baseline care plan within 48 hours of admission to the facility. DON or designee will complete audit of residents to ensure baseline careplans are completed within 48 hours of admission to ensure immediate care needs are identified. Audits will be completed three times a week for 6 weeks with any concerns being brought to the DON for immediate follow-up. Results will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met	06/09/2026

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F0655 SS = D	Continued from page 13 (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to develop a baseline care plan to ensure immediate care needs for surgical incision care and his urinary incontinence were addressed for 1 of 3 residents (R2) reviewed. R2's progress note, dated 4/13/26, identified R2 admitted to the care center and had several medical conditions including peripheral arterial disease (PAD), acute kidney injury, chronic kidney disease (CKD), and high blood pressure. R2 needed assistance for all activities of daily living (ADLs), needed cues and reminders to ask for help, and was alert and oriented to self. The note identified R2 had been incontinent of urine and was unaware of such. Further, the note included a section labeled "Skin" that identified, " ... two healing surgical sites in bilateral groin ... Bruising to BUE [bilateral upper	F0655		06/09/2026

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F0655 SS = D	Continued from page 14 extremities] ... Small scabbed area to posterior calf on LLE [left lower extremity ... All areas OTA [open to air] and not draining. No redness, swelling, or warmth to peri-wounds." R2's Care Plan, dated 4/22/26, identified all the potential or actual problems R2 had, along with goals and interventions to address them. This identified a section labeled "Category: Bowel & Bladder Function" that recorded R2 as having bladder and bowel incontinence along with interventions to address it, which included keeping the call light within reach, monitoring for signs of infection, providing R2 with the urinal/bedpan/commode as needed, and offering him toileting frequently. However, this section of the care plan and its interventions were initiated on 4/20/26 (seven days after admission). The care plan continued and listed a section labeled "Category: Pressure Ulcer/Injury" that recorded R2 as admitting with multiple surgical incisions and being at risk of skin breakdown. The plan listed several interventions including monitoring the skin, being involved in the treatment process, and applying barrier creams if needed. However, again, this section and its interventions were initiated on 4/20/26 (seven days after admission). R2's medical record lacked evidence that a comprehensive baseline care plan had been developed within 48 hours of admission to address these areas of R2's care despite him having active surgical wounds and being incontinent of urine upon admission as recorded in the progress notes. When interviewed on 5/12/26 at 1:24 p.m., nursing assistant (NA)-A stated they recalled working with R2. NA-A explained R2 needed help to use the bathroom and would, at times, refuse basic cares like getting cleaned up. NA-A stated they recalled trying to reposition R2 every few hours and were unsure if he ever had skin issues or wounds adding, "I don't remember that." When interviewed on 5/12/26 at 1:27 p.m., licensed practical nurse (LPN)-C stated the facility did not use a specific baseline care plan but rather just started to build the comprehensive one upon admission. LPN-C stated care plans were made usually by the nurse managers, director of nursing (DON) and social worker team as they reviewed the evaluations the floor staff completed. LPN-C reviewed R2's care plan and verified the skin and bladder/bowel sections were initiated on 4/20/26 which was a week after R2 was admitted to the center. LPN-C stated the baseline care plan should	F0655		06/09/2026

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F0655 SS = D	Continued from page 15 be done within "a few days" after admission. LPN-C stated having a baseline care plan was important as it assisted the staff with caring for the person in the early part of their admission. On 5/13/26 at 10:33 a.m., the DON and administrator were interviewed. DON explained that the MDS (Minimum Data Set) nurses helped complete the care plan by reviewing the floor staff observations and evaluations which included a toileting plan, if needed. DON verified there was not a separate baseline care plan template used and that R2's skin or bladder/bowel plans were not initiated until 4/20/26. DON stated they should have been initiated within 48 hours after admission to the care center but with weekend admission it could "take a little bit longer" at times. DON stated they would be doing education on this to the staff and added having a baseline care plan was important for the staff to know how to care for the resident. A provided Comprehensive Assessments and Care Planning policy, dated 2/2026, identified the assessment process of a resident begins with the development of the baseline care plan within the first 48 hours of admission. The plan should have the minimum healthcare information needed to care for them on admission including but not limited to their initial goals, physician orders, dietary orders, and social services. The policy continued, "The baseline care plan reflects the resident's stated goals and objective, and includes interventions that address his or her current needs."	F0655		06/09/2026
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F0690	R2 is no longer a resident in the facility. All facility residents with urinary incontinence were comprehensively reviewed to determine if a toileting program was appropriate to promote urinary continence. Care plans revised as necessary. All licensed nursing staff will be educated on necessary toileting program identification and implementation to promote urinary continence and individualized interventions to prevent complications and to provide skin protection and infection prevention. DON or designee will complete audit of residents to ensure comprehensive bladder assessment are completed, toileting program considered and implemented when indicated, and that resident care plan reflects current continence status with	06/09/2026

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F0690 SS = D	Continued from page 16 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and, if needed, develop a toileting program to promote urinary continence and reduce the risk of complication (i.e., skin infection, breakdown) for 1 of 3 residents (R2) reviewed. On 5/12/26 at 12:35 p.m., R2's family member (FM)-D was interviewed. R2 was admitted to the care center after being hospitalized for an extended period due to multiple conditions and he had used a catheter while in the hospital, but it was removed before he discharged to the care center on 4/13/26. FM-D stated R2 was "doing good" with using the bathroom and able to sense the need to go when he left the hospital. R2 also had some healing surgical incisions near his groin which were all intact and open-to-air (OTA). However, then they opened while at the care center and R2 had to eventually go back to the hospital due to them being re-opened and becoming infected. FM-D stated the family had visited at times and found R2 to be incontinent of urine which made them question if that contributed to the incisions becoming infected, adding, "Nursing 101 is keep the incision sites clean and dry." FM-D stated they were unsure if R2 ever attempted or was placed on a toileting plan while in the care center to help reduce the incontinence. R2's progress note, dated 4/13/26, identified R2 admitted to the care center and had several medical conditions including peripheral arterial disease (PAD), acute kidney injury, chronic kidney disease (CKD), and high blood pressure. R2 needed	F0690	Continued from page 16 individualized interventions. Audits will be completed three times a week for 6 weeks with any concerns being brought to the DON for immediate follow-up. Results will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245426	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OWATONNA	2255 30TH STREET NW , OWATONNA, Minnesota, 55060

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F0690 SS = D	Continued from page 17 assistance for all activities of daily living (ADLs), needed cues and reminders to ask for help, and was alert and oriented to self. The note identified R2 had been incontinent of urine and was unaware of such. Further, the note included a section labeled "Skin" that identified, " ... two healing surgical sites in bilateral groin ... Bruising to BUE [bilateral upper extremities] ... Small scabbed area to posterior calf on LLE [left lower extremity ... All areas OTA [open to air] and not draining. No redness, swelling, or warmth to peri-wounds." R2's Clinical Documentation (Admission), dated 4/13/26, identified a review of system completed upon admission. This identified R2 as needing supervision to complete a toileting transfer and partial/moderate assistance with toileting hygiene. The evaluation listed a section labeled "Bowel and Bladder" that identified R2 used no appliances, was frequently incontinent of urine and occasionally incontinent of bowel. There was no further assessment of R2's incontinence or dictation of what, if any, toileting program was needed, considered or attempted. R2's Bladder evaluation, dated 4/17/26, identified R2 used no appliances for elimination and was recorded as being frequently incontinent of urine. R2 was unable to recognize the appropriate time or place to urinate but was able to sense the urge to void. R2 had impaired mobility and severe cognitive impairment and was currently incontinent of bladder with his clothes being found wet. The evaluation listed multiple sections to be completed which included "Section 5 - Further Assessment" that had space to record a physical examination, a post-void residual (PVR), and if a urinalysis was performed, along with spacing to write the results. However, this section was left entirely blank and not completed. The section labeled "Section 6 - Incontinence Symptom Profile" had options to select which type of incontinence R2 was assessed to have present (i.e., urge, functional), however, this section was also left blank with nothing being selected or recorded. The section labeled "Section 7 - Summary of Program Placement Decision" identified R2 with functional incontinence, however, the remainder of the section, including spacing to record what toileting program was needed or if was not appropriate, was left blank and not completed. The evaluation concluded with summarized findings reading, "Resident incontinent of bladder. Does ask for urinal at times. Known to attempt urinal per self however not appropriately. Staff assist with incontinence cares." The evaluation was completed by licensed practical nurse (LPN)-C.	F0690		06/09/2026

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F0690 SS = D	Continued from page 18 R2's admission Minimum Data Set (MDS), dated 4/19/26, identified R2 admitted to the care center on 4/13/26 from the acute-care hospital. The MDS identified R2 had severe cognitive impairment and had surgical wounds present. Further, the MDS identified R2 used no elimination appliances (i.e., catheter) and was recorded as always incontinent of bowel and bladder; however, a toileting program had not been attempted since admission. R2's corresponding Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 4/21/26, identified R2 had no modifiable risk factors identified, demonstrated urinary urgency and needed assist with toileting, and demonstrated functional incontinence (i.e., can't get to toilet timely). The CAA identified, "CAA triggered due to resident is always incontinent of urine. Contributing factors include need for staff to assist with toileting. He is at risk for skin rashes, skin breakdown, and urinary infection. No referrals at this time. Will proceed to care plan to minimize risks." The CAA did not address if a toileting plan was considered, appropriate, or rationale why not to attempt one despite the incontinence and R2 being recorded as using the urinal at times. R2's Care Plan, dated 4/22/26, identified all the potential or actual problems R2 had along with goals and interventions to address them. This identified a section labeled "Category: Bowel & Bladder Function" that recorded R2 as having bladder and bowel incontinence along with interventions to address it including keeping the call light within reach, monitoring for signs of infection, providing R2 with the urinal/bedpan/commode as needed, and offering him toileting "frequently." This section of the care plan and its interventions were initiated on 4/20/26 (seven days after admission) and the plan lacked any further dictation or description of what "frequently" meant for his toileting. When interviewed on 5/12/26 at 1:24 p.m., nursing assistant (NA)-A stated they recalled working with R2. NA-A explained R2 needed help to use the bathroom and would, at times, refuse basic cares like getting cleaned up. NA-A stated they tried to help R2 with toileting every few hours or when he used the call light asking for the urinal. NA-A stated R2 was able to sense when he needed to void and would "off and on" use the call light to alert staff. NA-A stated they did not recall if R2 was on a formal toileting program or not but reiterated R2 would tell them if he needed to use the bathroom or not adding, "He usually told us."	F0690		06/09/2026

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F0690 SS = D	Continued from page 19 R2's medical record was reviewed and lacked evidence R2 had been comprehensively assessed for his bladder function and incontinence including to determine what, if any, toileting program may be beneficial for R2 since he was able to sense the need to void, could alert staff for assistance, and had active healing surgical wounds around his groin, which were at risk for infection. When interviewed on 5/12/26 1:27 p.m., LPN-C verified they completed the bladder evaluation for R2 (dated 4/17/26) and explained upon admission each resident has the Clinical Documentation evaluation completed and a Bladder evaluation completed after that. This should happen within the first seven (7) days after admission. LPN-C reviewed R2's completed Bladder evaluation and stated the section for a physical assessment (Section 5) was often not completed unless someone had a recent appliance removed or had pending lab results. LPN-C verified this was left blank on R2's evaluation (despite him using a catheter in the hospital for a period). The section for the incontinence profile (Section 6) was used to record the incontinence type and LPN-C verified the areas not completed and responded, "You're right." LPN-C stated they could have completed that section and there was "a missing aspect under that [section]." LPN-C stated the section for the toileting program determination (Section 7) was also left nearly blank and acknowledged no decision for a program adding, "You're right." LPN-C stated they were unsure why they didn't complete the evaluation and program selection adding, "I guess I can't answer that." LPN-C stated the center rarely used a three-day tracking diary or other tool to evaluate potential toileting programs, but the staff could check the recorded point-of-care (POC) responses if needed, but added, "I personally do, but can't speak for others." On 5/13/26 at 10:33 a.m., the director of nursing (DON) and administrator were interviewed. DON explained that the Bladder evaluation is completed after a few days from admission and the MDS nurses will then develop a care plan from that information and determine if a toileting program should be implemented with therapies (PT/OT) able to give input on that decision. DON stated the center didn't do a toileting program often, rather just did basic plans like assistance before meals, after meals, and as requested. DON stated the word "frequently" was a "very vague term" on the care plan. DON explained each section of the Bladder evaluation and stated they expected the sections left all or mostly blank on R2's evaluation (i.e., 5 - 7) to be	F0690		06/09/2026

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F0690 SS = D	Continued from page 20 completed. This was important to do as "it's a requirement" and helps staff to have a "clearer picture of the resident." DON acknowledged the record lacked evidence or rationale why this had not been done for R2. A facility policy on bladder evaluations was requested; however, none was received.	F0690		06/09/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure high-risk medications were provided timely after being ordered to help prevent potential blood clots for 1 of 1 resident (R1) reviewed. R1 had Eliquis (an	F0755	R1 is no longer a resident of the facility. All residents who have admitted or readmitted within the past 30 days with newly ordered anticoagulation medications were reviewed to ensure physician orders were transcribed accurately and initiated timely. Any concerns or discrepancies were communicated to the provider. All licensed nursing staff will be educated on timely implementation of anticoagulation medications and use/ availability of E-Kit medications. DON or designee will complete audit of resident orders to ensure timely implementation of anticoagulation medications and appropriate use of E-Kit when indicated. Audits will be completed three times a week for 6 weeks with any concerns being brought to the DON for immediate follow-up. Results will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	06/09/2026

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F0755 SS = D	Continued from page 21 anticoagulant, blood thinning, medication) ordered by the medical doctor (MD)-A on 4/10/26; however, this was not provided to R1 until 4/12/26 despite supply of the medication available in the emergency kit (E-Kit) onsite. R1's Hospitalist Discharge Summary, dated 4/1/26, identified R1 would be transitioned to the care center and listed a principal problem, "Acute cholecystitis (gallbladder inflammation)." R1's other active problems included high blood pressure, heart failure, and atrial fibrillation (irregular heart rhythm). R1 was described as a 93-year-old female who admitted to the hospital on 3/25/26 with acute cholecystitis and underwent surgery for this condition. R1 then developed atrial fibrillation with rapid ventricular rate (RVR). The summary outlined, "Eliquis on hold postoperatively." R1 discharged the hospital with a Jackson Pratt (JP) drain in place and would follow up in the general surgery clinic. The note added, "She will hold Eliquis until JP drain is removed." R1's corresponding After Discharge Orders, dated 4/1/26, identified R1's hospital discharge orders. These listed a section labeled, "Discharge Medications" that contained two medications listed under the heading, "PAUSE taking these medications." One of the medications listed under this heading identified the Eliquis and directions below, "Wait to take this until your doctor or other care provider tells you to start again. After JP [Jackson Pratt] drain is out." The orders included no other anticoagulant medications. R1's Progress Note, dated 4/6/26, identified R1 was seen by the general surgery service for post-operative follow up. The note identified the surgery was on 3/26/26, and the patient was "doing well" and the JP drain had not had output for "a few days." The JP drain was removed, and the site was reapproximated with Steri-Strips. The note identified sections below the dictation that read, "Orders Placed," and "Medication Changes," but these were both answered with text reading, "None." The note did not address R1's Eliquis, which remained on hold since she was admitted to the care center six days prior. R1's H&P (History & Physical), dated 4/10/26, identified R1 was seen by the medical doctor (MD)-A for a routine nursing home visit. The note recorded, "Since discharge she feels generally well and has no nausea. She has significant fatigue ... she notes an irregular heartbeat." The note listed a section labeled, "ASSESSMENT/PLAN," which reviewed each medical condition and subsequent orders for	F0755		06/09/2026

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F0755 SS = D	Continued from page 22 them. This included, "Atrial Fibrillation Paroxysmal (HCC)," and dictation which read, "Persistent with mildly elevated ventricular rate after recent sepsis hospitalization ... Apixaban [Eliquis] was to be restarted when JP drain was removed. I wrote that order today." R1's subsequent order, dated 4/10/26, identified directions which included taking Eliquis 2.5 mg orally twice a day. The order was signed by MD-A on 4/10/26 at 9:31 p.m., and the fax was time-stamped as received by the care center at 9:33 p.m. R1's Medication Administration Record (MAR), dated 4/2026, identified R1's administered medications for the month period. This included an order for Eliquis 2.5 mg twice a day with dates recorded, "04/11/2026 - 4/15/2026." The medication was recorded as not being administered on 4/11/26 for either dose with comments written, "Other ... pharmacy will deliver med ASAP," and "Drug/Item unavailable." R1's first recorded dose of the Eliquis was on 4/12/26 in the morning (AM) hours. R1's progress note, dated 4/15/26, identified the nursing assistant (NA) reported R1 sat on her bedside and was unable to move her left leg. The note recorded the leg, " ... appeared to be difference [sic] in color and cooler than right side ... resident said that she couldn't feel sensation on left foot. Called for ambulance and called daughter ... left via ambulance ...." When interviewed on 5/12/26 at 10:24 a.m., licensed practical nurse (LPN)-C reviewed R1's medical record and explained she was admitted to the care center following gallbladder surgery with a JP drain in place. LPN-C reviewed R1's Eliquis and stated the order to resume it was faxed to the center on 4/10/26 late in the evening and entered in the EMR to begin on 4/11/26. LPN-C acknowledged the doses on 4/11/26 were not administered and expressed they were unsure why it wasn't given as a supply of Eliquis was available in the onsite emergency kit (E-kit). LPN-C retrieved a black-colored binder that had the E-Kit supply listed and Eliquis was included. LPN-C then showed the surveyor the medication room which had an AlixaRx machine present. On the front of the machine, a white-colored paper was taped with the medications available. Eliquis was listed and the paper was dated, "4-Nov-24." Further, LPN-C stated Eliquis was considered a high-risk medication and not getting the medication resumed timely when ordered would be a concern adding aloud, "It's significant." On 5/12/26 at 1:59 p.m., unit nurse manager (RN)-B,	F0755		06/09/2026

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F0755 SS = D	Continued from page 23 the director of nursing (DON), and administrator were interviewed. DON explained the pharmacy sends medications to the campus once a day usually in the early morning hours, so an order received late at night wouldn't likely arrive the following day, however, the E-Kit was available and had some of that medication inside at the time on 4/11/26 to at least provide a dose. DON stated they would consider Eliquis to be a high-risk medication, and it should be given timely when ordered to help prevent blood clots. When interviewed on 5/12/26 at 2:32 p.m., MD-A stated they were the campus' medical director and reviewed R1's Eliquis. MD-A visited R1 on 4/10/26 and on that day learned it was to be restarted but were unsure if they identified that themselves or if the nurses at the center raised the issue with them. MD-A stated when they saw R1 on 4/10/26, there was no concern for a blood clot in her leg at that time, so the clotting most likely happened after that visit. MD-A stated if the medication was available in the E-Kit on 4/11/26 then a dose could have been removed and provided immediately following the order on 4/10/26 adding, "That would be a med I would administer sooner rather than later." On 5/12/26 at 3:23 p.m., the dispensing pharmacist (DP)-A was interviewed and verified their service distributed the medications to the campus. DP-A stated their current formulary showed Eliquis as being available in the campus E-Kit, but they would have to check and then send a review of the "retrospective inventory" after the interview to confirm a medication supply was available on 4/11/26. DP-A stated nurses were always able to call them and ask about medication supply if they had questions about it. DP-A stated Eliquis was a medication the patient should not be without for a long period and explained the "half-life" of the medication (the time it takes for the concentration of that drug in your body to reduce by exactly 50%) was about 12 hours, and the medication starts working within an hour of being given. If a patient went for several days without it, then the effects of the medication would likely be totally removed from the body systems. DP-A stated having a period of multiple days between an order and actual administration would make a difference with the risk of blood clots being formed adding, "It would matter something." An e-mail correspondence received from DP-A on 5/12/26 at 5:28 p.m., identified Eliquis was available with at least one dose in the E-Kit on 4/11/26. The email identified, "It appears that the facility had a	F0755		06/09/2026

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F0755 SS = D	Continued from page 24 balance on hand in their [kit] to initiate therapy before the cards were delivered." A provided Emergency Pharmacy Service and Emergency Kits policy, dated 12/2017, identified emergency pharmacy services were available on a 24-hour basis through the approved emergency medication supply. The supply was maintained in the ADU (automated dispensing unit) room along with a list of supply and expiration dates. The policy then listed a procedure to withdraw and use the medication and document it on the medical record.	F0755		06/09/2026

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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 5/12/26 to 5/13/26, a complaint survey was conducted at your facility by a surveyor 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 and identify the date when they will be completed. The following complaints were reviewed: H54262047C (3006067); order issued at 1550.	20000		05/28/2026

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

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BENEDICTINE LIVING COMMUNITY OWATONNA	**2255 30TH STREET NW , OWATONNA, Minnesota, 55060**

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20000	Continued from page 1 H54261699C (2996678); order issued at 0910. 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 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 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.	20000		05/28/2026
20910	Rehab - Incontinence CFR(s): MN Rule 4658.0525 Subp. 5 A.B Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the	20910		06/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/13/2026**

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20910	Continued from page 2 resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and, if needed, develop a toileting program to promote urinary continence and reduce the risk of complication (i.e., skin infection, breakdown) for 1 of 3 residents (R2) reviewed. On 5/12/26 at 12:35 p.m., R2's family member (FM)-D was interviewed. R2 was admitted to the care center after being hospitalized for an extended period due to multiple conditions and he had used a catheter while in the hospital, but it was removed before he discharged to the care center on 4/13/26. FM-D stated R2 was "doing good" with using the bathroom and able to sense the need to go when he left the hospital. R2 also had some healing surgical incisions near his groin which were all intact and open-to-air (OTA). However, then they opened while at the care center and R2 had to eventually go back to the hospital due to them being re-opened and becoming infected. FM-D stated the family had visited at times and found R2 to be incontinent of urine which made them question if that contributed to the incisions becoming infected, adding, "Nursing 101 is keep the incision sites clean and dry." FM-D stated they were unsure if R2 ever attempted or was placed on a toileting plan while in the care center to help reduce the incontinence. R2's progress note, dated 4/13/26, identified R2 admitted to the care center and had several medical conditions including peripheral arterial disease (PAD), acute kidney injury, chronic kidney disease (CKD), and high blood pressure. R2 needed assistance for all activities of daily living (ADLs), needed cues and reminders to ask for help, and was alert and oriented to self. The note identified R2 had been incontinent of urine and was unaware of such. Further, the note included a section labeled "Skin" that identified, " ... two healing surgical sites in bilateral groin ... Bruising to BUE [bilateral upper extremities] ... Small scabbed area to posterior calf on LLE [left lower extremity ... All areas OTA [open to air] and not draining. No redness, swelling, or warmth to peri-wounds."	20910		06/09/2026

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20910	Continued from page 3 R2's Clinical Documentation (Admission), dated 4/13/26, identified a review of system completed upon admission. This identified R2 as needing supervision to complete a toileting transfer and partial/moderate assistance with toileting hygiene. The evaluation listed a section labeled "Bowel and Bladder" that identified R2 used no appliances, was frequently incontinent of urine and occasionally incontinent of bowel. There was no further assessment of R2's incontinence or dictation of what, if any, toileting program was needed, considered or attempted. R2's Bladder evaluation, dated 4/17/26, identified R2 used no appliances for elimination and was recorded as being frequently incontinent of urine. R2 was unable to recognize the appropriate time or place to urinate but was able to sense the urge to void. R2 had impaired mobility and severe cognitive impairment and was currently incontinent of bladder with his clothes being found wet. The evaluation listed multiple sections to be completed which included "Section 5 - Further Assessment" that had space to record a physical examination, a post-void residual (PVR), and if a urinalysis was performed, along with spacing to write the results. However, this section was left entirely blank and not completed. The section labeled "Section 6 - Incontinence Symptom Profile" had options to select which type of incontinence R2 was assessed to have present (i.e., urge, functional), however, this section was also left blank with nothing being selected or recorded. The section labeled "Section 7 - Summary of Program Placement Decision" identified R2 with functional incontinence, however, the remainder of the section, including spacing to record what toileting program was needed or if was not appropriate, was left blank and not completed. The evaluation concluded with summarized findings reading, "Resident incontinent of bladder. Does ask for urinal at times. Known to attempt urinal per self however not appropriately. Staff assist with incontinence cares." The evaluation was completed by licensed practical nurse (LPN)-C. R2's admission Minimum Data Set (MDS), dated 4/19/26, identified R2 admitted to the care center on 4/13/26 from the acute-care hospital. The MDS identified R2 had severe cognitive impairment and had surgical wounds present. Further, the MDS identified R2 used no elimination appliances (i.e., catheter) and was recorded as always incontinent of bowel and bladder; however, a toileting program had not been attempted since admission. R2's corresponding Urinary Incontinence and Indwelling	20910		06/09/2026

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20910	Continued from page 4 Catheter Care Area Assessment (CAA), dated 4/21/26, identified R2 had no modifiable risk factors identified, demonstrated urinary urgency and needed assist with toileting, and demonstrated functional incontinence (i.e., can't get to toilet timely). The CAA identified, "CAA triggered due to resident is always incontinent of urine. Contributing factors include need for staff to assist with toileting. He is at risk for skin rashes, skin breakdown, and urinary infection. No referrals at this time. Will proceed to care plan to minimize risks." The CAA did not address if a toileting plan was considered, appropriate, or rationale why not to attempt one despite the incontinence and R2 being recorded as using the urinal at times. R2's Care Plan, dated 4/22/26, identified all the potential or actual problems R2 had along with goals and interventions to address them. This identified a section labeled "Category: Bowel & Bladder Function" that recorded R2 as having bladder and bowel incontinence along with interventions to address it including keeping the call light within reach, monitoring for signs of infection, providing R2 with the urinal/bedpan/commode as needed, and offering him toileting "frequently." This section of the care plan and its interventions were initiated on 4/20/26 (seven days after admission) and the plan lacked any further dictation or description of what "frequently" meant for his toileting. When interviewed on 5/12/26 at 1:24 p.m., nursing assistant (NA)-A stated they recalled working with R2. NA-A explained R2 needed help to use the bathroom and would, at times, refuse basic cares like getting cleaned up. NA-A stated they tried to help R2 with toileting every few hours or when he used the call light asking for the urinal. NA-A stated R2 was able to sense when he needed to void and would "off and on" use the call light to alert staff. NA-A stated they did not recall if R2 was on a formal toileting program or not but reiterated R2 would tell them if he needed to use the bathroom or not adding, "He usually told us." R2's medical record was reviewed and lacked evidence R2 had been comprehensively assessed for his bladder function and incontinence including to determine what, if any, toileting program may be beneficial for R2 since he was able to sense the need to void, could alert staff for assistance, and had active healing surgical wounds around his groin, which were at risk for infection. When interviewed on 5/12/26 1:27 p.m., LPN-C verified they completed the bladder evaluation for R2	20910		06/09/2026

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20910	Continued from page 5 (dated 4/17/26) and explained upon admission each resident has the Clinical Documentation evaluation completed and a Bladder evaluation completed after that. This should happen within the first seven (7) days after admission. LPN-C reviewed R2's completed Bladder evaluation and stated the section for a physical assessment (Section 5) was often not completed unless someone had a recent appliance removed or had pending lab results. LPN-C verified this was left blank on R2's evaluation (despite him using a catheter in the hospital for a period). The section for the incontinence profile (Section 6) was used to record the incontinence type and LPN-C verified the areas not completed and responded, "You're right." LPN-C stated they could have completed that section and there was "a missing aspect under that [section]." LPN-C stated the section for the toileting program determination (Section 7) was also left nearly blank and acknowledged no decision for a program adding, "You're right." LPN-C stated they were unsure why they didn't complete the evaluation and program selection adding, "I guess I can't answer that." LPN-C stated the center rarely used a three-day tracking diary or other tool to evaluate potential toileting programs, but the staff could check the recorded point-of-care (POC) responses if needed, but added, "I personally do, but can't speak for others." On 5/13/26 at 10:33 a.m., the director of nursing (DON) and administrator were interviewed. DON explained that the Bladder evaluation is completed after a few days from admission and the MDS nurses will then develop a care plan from that information and determine if a toileting program should be implemented with therapies (PT/OT) able to give input on that decision. DON stated the center didn't do a toileting program often, rather just did basic plans like assistance before meals, after meals, and as requested. DON stated the word "frequently" was a "very vague term" on the care plan. DON explained each section of the Bladder evaluation and stated they expected the sections left all or mostly blank on R2's evaluation (i.e., 5 - 7) to be completed. This was important to do as "it's a requirement" and helps staff to have a "clearer picture of the resident." DON acknowledged the record lacked evidence or rationale why this had not been done for R2. A facility policy on bladder evaluations was requested; however, none was received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review	20910		06/09/2026

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20910	Continued from page 6 applicable policies on comprehensive bladder assessments and care planning and educate floor staff, then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	20910		06/09/2026
21550	Adminiatration of Medications; Pharmacy Serv. CFR(s): MN Rule 4658.1325 Subp. 1 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure high-risk medications were provided timely after being ordered to help prevent potential blood clots for 1 of 1 resident (R1) reviewed. R1 had Eliquis (an anticoagulant, blood thinning, medication) ordered by the medical doctor (MD)-A on 4/10/26; however, this was not provided to R1 until 4/12/26 despite supply of the medication available in the emergency kit (E-Kit) onsite. R1's Hospitalist Discharge Summary, dated 4/1/26, identified R1 would be transitioned to the care center and listed a principal problem, "Acute cholecystitis (gallbladder inflammation)." R1's other active problems included high blood pressure, heart failure, and atrial fibrillation (irregular heart rhythm). R1 was described as a 93-year-old female who admitted to the hospital on 3/25/26 with acute cholecystitis and underwent surgery for this condition. R1 then developed atrial fibrillation with rapid ventricular rate (RVR). The summary outlined, "Eliquis on hold postoperatively." R1 discharged the hospital with a Jackson Pratt (JP) drain in place and would follow up in the general surgery clinic. The note added, "She will hold Eliquis until JP drain is removed." R1's corresponding After Discharge Orders, dated 4/1/26, identified R1's hospital discharge orders. These listed a section labeled, "Discharge Medications" that contained two medications listed under the heading, "PAUSE taking these medications." One of the medications listed under this heading identified the Eliquis and directions below, "Wait to take this until your doctor or other care provider tells you to start again. After JP [Jackson Pratt] drain is out." The orders included no other anticoagulant medications.	21550		06/09/2026

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21550	Continued from page 7 R1's Progress Note, dated 4/6/26, identified R1 was seen by the general surgery service for post-operative follow up. The note identified the surgery was on 3/26/26, and the patient was "doing well" and the JP drain had not had output for "a few days." The JP drain was removed, and the site was reapproximated with Steri-Strips. The note identified sections below the dictation that read, "Orders Placed," and "Medication Changes," but these were both answered with text reading, "None." The note did not address R1's Eliquis, which remained on hold since she was admitted to the care center six days prior. R1's H&P (History & Physical), dated 4/10/26, identified R1 was seen by the medical doctor (MD)-A for a routine nursing home visit. The note recorded, "Since discharge she feels generally well and has no nausea. She has significant fatigue ... she notes an irregular heartbeat." The note listed a section labeled, "ASSESSMENT/PLAN," which reviewed each medical condition and subsequent orders for them. This included, "Atrial Fibrillation Paroxysmal (HCC)," and dictation which read, "Persistent with mildly elevated ventricular rate after recent sepsis hospitalization ... Apixaban [Eliquis] was to be restarted when JP drain was removed. I wrote that order today." R1's subsequent order, dated 4/10/26, identified directions which included taking Eliquis 2.5 mg orally twice a day. The order was signed by MD-A on 4/10/26 at 9:31 p.m., and the fax was time-stamped as received by the care center at 9:33 p.m. R1's Medication Administration Record (MAR), dated 4/2026, identified R1's administered medications for the month period. This included an order for Eliquis 2.5 mg twice a day with dates recorded, "04/11/2026 - 4/15/2026." The medication was recorded as not being administered on 4/11/26 for either dose with comments written, "Other ... pharmacy will deliver med ASAP," and "Drug/Item unavailable." R1's first recorded dose of the Eliquis was on 4/12/26 in the morning (AM) hours. R1's progress note, dated 4/15/26, identified the nursing assistant (NA) reported R1 sat on her bedside and was unable to move her left leg. The note recorded the leg, " ... appeared to be difference [sic] in color and cooler than right side ... resident said that she couldn't feel sensation on left foot. Called for ambulance and called daughter ... left via ambulance ...." When interviewed on 5/12/26 at 10:24 a.m., licensed practical nurse (LPN)-C reviewed R1's medical	21550		06/09/2026

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21550	Continued from page 8 record and explained she was admitted to the care center following gallbladder surgery with a JP drain in place. LPN-C reviewed R1's Eliquis and stated the order to resume it was faxed to the center on 4/10/26 late in the evening and entered in the EMR to begin on 4/11/26. LPN-C acknowledged the doses on 4/11/26 were not administered and expressed they were unsure why it wasn't given as a supply of Eliquis was available in the onsite emergency kit (E-kit). LPN-C retrieved a black-colored binder that had the E-Kit supply listed and Eliquis was included. LPN-C then showed the surveyor the medication room which had an AlixaRx machine present. On the front of the machine, a white-colored paper was taped with the medications available. Eliquis was listed and the paper was dated, "4-Nov-24." Further, LPN-C stated Eliquis was considered a high-risk medication and not getting the medication resumed timely when ordered would be a concern adding aloud, "It's significant." On 5/12/26 at 1:59 p.m., unit nurse manager (RN)-B, the director of nursing (DON), and administrator were interviewed. DON explained the pharmacy sends medications to the campus once a day usually in the early morning hours, so an order received late at night wouldn't likely arrive the following day, however, the E-Kit was available and had some of that medication inside at the time on 4/11/26 to at least provide a dose. DON stated they would consider Eliquis to be a high-risk medication, and it should be given timely when ordered to help prevent blood clots. When interviewed on 5/12/26 at 2:32 p.m., MD-A stated they were the campus' medical director and reviewed R1's Eliquis. MD-A visited R1 on 4/10/26 and on that day learned it was to be restarted but were unsure if they identified that themselves or if the nurses at the center raised the issue with them. MD-A stated when they saw R1 on 4/10/26, there was no concern for a blood clot in her leg at that time, so the clotting most likely happened after that visit. MD-A stated if the medication was available in the E-Kit on 4/11/26 then a dose could have been removed and provided immediately following the order on 4/10/26 adding, "That would be a med I would administer sooner rather than later." On 5/12/26 at 3:23 p.m., the dispensing pharmacist (DP)-A was interviewed and verified their service distributed the medications to the campus. DP-A stated their current formulary showed Eliquis as being available in the campus E-Kit, but they would have to check and then send a review of the "retrospective inventory" after the interview to	21550		06/09/2026

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21550	Continued from page 9 confirm a medication supply was available on 4/11/26. DP-A stated nurses were always able to call them and ask about medication supply if they had questions about it. DP-A stated Eliquis was a medication the patient should not be without for a long period and explained the "half-life" of the medication (the time it takes for the concentration of that drug in your body to reduce by exactly 50%) was about 12 hours, and the medication starts working within an hour of being given. If a patient went for several days without it, then the effects of the medication would likely be totally removed from the body systems. DP-A stated having a period of multiple days between an order and actual administration would make a difference with the risk of blood clots being formed adding, "It would matter something." An e-mail correspondence received from DP-A on 5/12/26 at 5:28 p.m., identified Eliquis was available with at least one dose in the E-Kit on 4/11/26. The email identified, "It appears that the facility had a balance on hand in their [kit] to initiate therapy before the cards were delivered." A provided Emergency Pharmacy Service and Emergency Kits policy, dated 12/2017, identified emergency pharmacy services were available on a 24-hour basis through the approved emergency medication supply. The supply was maintained in the ADU (automated dispensing unit) room along with a list of supply and expiration dates. The policy then listed a procedure to withdraw and use the medication and document it on the medical record. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies on emergency medication use from the onsite emergency kit (E-Kit) and educate floor staff, then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21550		06/09/2026