



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 24, 2025

Administrator
Benedictine Care Community
201 9TH STREET WEST
ADA, MN 56510

RE: CCN: 245502

Cycle Start Date: August 16, 2025

Dear Administrator:

On October 16, 2025 we notified you a remedy was imposed. The Minnesota Departments of Health completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 27, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 31, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 27, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 31, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 27, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 24, 2025

Administrator
Benedictine Care Community

201 9TH STREET WEST
ADA, MN 56510

Re: Reinspection Results
Event ID: 1D42F4-H1

Dear Administrator:

On November 12, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 21, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 10, 2025

Administrator
Benedictine Care Community

201 9TH STREET WEST
ADA, MN 56510

RE: CCN:245502

Cycle Start Date: August 21, 2025

Dear Administrator:

On August 21, 2025 a survey was completed at your facility by the Minnesota Departments 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section

above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by November 21, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 21, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have

one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 10, 2025

Administrator
Benedictine Care Community
201 9TH STREET WEST
ADA, MN 56510

Re: State Nursing Home Licensing Orders
Event ID: 1D42F4-H1

Dear Administrator:

The above facility survey was completed on August 21, 2025 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 8/19/25 through 8/21/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H55021481C (2579534) with deficiencies issued at F558, F676 and F688. 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			
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to meet resident care requests timely and promote resident dignity for 4 of 4 residents (R1, R2, R4) when call lights were not answered timely. Findings include: R1's quarterly Minimum Data Set (MDS) dated 5/16/25, identified she had intact cognition and no behaviors.			F0558			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0558 SS = D	Continued from page 1 She had impaired ROM (range of motion) upper and lower extremities bilaterally and used a walker and wheelchair for mobility. She was dependent to roll left and right, sit to lying, lying to sit, sit to stand, and all transfers, and substantial/maximal assistance to walk 10 feet, personal/toilet hygiene, and upper/lower body dressing. She was frequently incontinent of bladder and always continent of bowel. Diagnoses included diabetes mellitus (DM), arthritis, and manic depression. R1's care plan dated 5/14/25, identified self-care deficit related to hemiplegia (one sided weakness) due to cerebrovascular accident (CVA) (stroke) with activities of daily living (ADL). Goal: resident will be continent of bladder 100% of the time within the next 90 days. She used stand PAL lift for transfers with assist of two and required toileting every two hours while awake to help remain free of skin breakdown and respect her dignity. R1's call light activity log report from 7/2/25 through 8/20/25, identified a range from 18 to 29 minutes record for 15 resident-initiated calls. During an interview on 8/19/25 at 10:10 a.m. R1 laid in recliner covered with a blanket. She stated staff would take up to 30 minutes to answer her call light at times. which resulted in her having urine accidents because she was unable to make it to the bathroom on time and wore a brief. R1 stated she felt embarrassed when she had to "go in her pants" and had to be changed be staff following an accident. R2's quarterly MDS dated 6/27/25, identified she had intact cognition. She had limited ROM lower extremity on one side and used a manual wheelchair for mobility. She required partial/moderate assistance with sit to lying and lying to sitting, and upper body dressing, substantial/maximal assistance with shower/bathing, toileting/personnel hygiene, lower body dressing, roll left and right, sit to stand, and all transfers. She was occasionally incontinent of urine and always continent of bowel. Goal: resident will be continent of bladder. Diagnoses included above the right knee amputation, DM, anxiety, and depression. R2's care plan dated 7/5/25 identified a self-care deficit and required assistance with ADL. She required assist of one and gait belt to transfer from wheelchair to/from toilet and toileting need addressed. She was occasionally incontinent, and staff were directed to offer assistance with toileting about every three hours while awake. Goal: resident will be continent 7 out of			F0558			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community			STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0558 SS = D	Continued from page 2 7 days. R2's call light activity log report from 7/14/25 through 8/12/25, identified a range from 17 to 32 minutes record for 13 resident-initiated calls. During an interview on 8/20/25 at 1:25 p.m. R2 stated there were over 20 residents for two staff to take care of. She waited until she had more than one reason to call staff with call light so that they only had to come and assist her occasionally. The morning shift was quite busy, they need more help, had taken up to 30 minutes for staff to respond to her call light. She had sat in wheelchair, lacked muscle control, had bowel and bladder accidents daily. She was embarrassed when that happened especially when she was incontinent of bowel/stool, adding she had gone through three pairs of pants yesterday, R4's quarterly MDS dated 6/13/25, identified she had intact cognition with verbal behaviors directed towards others (e.g. threatening others, screaming at others, cursing at others) one to three times a week. She required partial/moderate assistance with lower body dressing, substantial/maximal assistance with personal hygiene, shower/bathing, sit to stand, all transfers, and walk 150 feet in corridor. She used a walker and manual wheelchair for mobility. She was frequently incontinent of bladder and always continent of bowel. Diagnoses included depression. R4's care plan dated 6/27/25, identified a self-care deficit with ADLs. She was frequently incontinent of urine. Goal: resident will be continent during the day within the next 90 days. She required extensive assistance of one with gait belt, wheeled walker to transfer, wipe, adjust clothing, and manage incontinence. R4's call light activity log report from 7/5/25 through 8/19/25, identified a range from 21 to 50 minutes record for 18 resident-initiated calls. During interview and observation on 8/21/25 at 10:30 a.m., R4 sat in her wheelchair with a call light pendent around her neck. She stated just the other day she was taken to bathroom, staff had forgotten about her, left for the day, so she placed the call light on and waited at least 30 minutes. She was scared to get up by herself due to a recent fall. R4 indicated about once a week she had an accident of stool and urine because she was unable to get to the bathroom in time. She wore a brief, had messed her pants, which made her feel bad and embarrassed. R4 stated, "who wants to show	F0558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0558 SS = D	Continued from page 3 up with a dirty butt?" Resident Council meeting minutes dated 5/13/25, identified department updates: concerns/comments – R2 was still being left in the bathroom for a long time with call light going off. Residents say call lights were going on for too long when they need help. During an interview on 8/19/25 at 12:13 p.m., nursing assistance (NA)-C stated staff were expected to answer call lights as soon as possible and had seen them left on up to 20 minutes frequently. There was a float staff that was scheduled to work both sides but did not always help when needed with call lights. There was a lack of teamwork and staff that just did not want to work. While she tried to provide appropriate care to residents, other staff saw call lights on and refused to answer them. She had found three residents located on the pioneer side soaked in urine and/or stool all in one day and had informed the staff nurse. During an interview on 8/19/25 at 2:41 p.m., NA-A stated we had walkies while she was in a room assisting a resident unable to leave, she had seen call lights on for up to 30 minutes and which was too long. Staff were expected to answer call lights as soon as possible to provide assistance. Management team had informed staff after five minutes the call light should be answered. The old management team would step in and provide assistance, that had changed dramatically with new management. During a combined interview on 8/21/25 at 12:22 p.m., director of nursing (DON) stated staff were expected to answer call lights as soon as possible at least within 10 minutes or less. The regional manager of clinical services (RMCS) stated nursing assistance would be expected to ask for assistance from the nurse when unable to assist with a call light. Management could have acknowledged the call light and reassure the resident when help would be there. The triage system would be used depending on the need. DON stated call lights answered in a timely manner would avoid long waiting times, provide assistance when needed, and if they had an emergency, they would have needed help. During an interview on 8/21/25 at 1:07 p.m., floor manager RN-B stated staff were expected to answer the call lights as soon as possible. When the call light hit the 10-minute mark other staff would get a page. This was a new system and had not been working and alarming us after the 10-minute mark. We also had company phones that alarmed us to when the call light went to the 10-minute mark so we could respond to them.		F0558				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0558 SS = D	Continued from page 4 Answering the call lights as soon as possible would provide safety, decrease falls, and provide assistance they needed in a timely manner.		F0558				
F0676 SS = E	Activities Daily Living (ADLs)/Mntrn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems.		F0676				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0676 SS = E	Continued from page 5 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure activities of daily living (ADLs) were provided for 4 of 4 residents (R1, R2, R3, R4) who required assistance with bathing. Findings include: R1’s quarterly Minimum Data Set (MDS) dated 5/16/25, identified she had intact cognition and no behaviors. She had impaired range of motion (ROM) upper and lower extremities bilaterally and used a walker and wheelchair for mobility. She was dependent to roll left and right, sit to lying, lying to sit, sit to stand, and all transfers, and substantial/maximal assistance to walk 10 feet, personal/toilet hygiene, and upper/lower body dressing. Diagnoses included diabetes mellitus (DM), arthritis, and manic depression. R1’s care plan dated 5/14/25, identified self-care deficit with bathing and personal hygiene. She would be clean and groomed. She required extensive assistance of one with bathing up to two times a week. R1’s nursing assistant (NA) care sheet undated, bath day not identified. R1’s Bath Schedule for the week of 8/17/25 through 8/23/25, identified bath day as Wednesday a.m. R1’s progress notes from 6/1/25 through 8/18/25, identified skin assessments were completed on the following dates in the progress notes and no bath was identified: 6/5/25, 6/12/25, 6/19/25, 6/26/25, 7/3/25, 7/10/25, 7/17/25, 7/24/25. R1’s progress notes from 6/1/25 through 8/17/25 identified skin assessments were completed on the following dates with a bath given: 7/31/25, 8/13/25, 8/20/25. R1’s weekly skin checks completed from 6/5/25 through 8/20/25 identified a bath was given: 6/5/25, 6/12/25, 6/26/25, 7/3/25, 7/17/25, 7/24/25, 8/13/25, 8/20/25.			F0676			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0676 SS = E	Continued from page 6 R1's point of care (POC) NA documentation from 6/1/25 through 8/20/25, identified a tub bath was given 6/16/25, and 7/14/25. Summary of bath/shower documentation from 6/1/25 through 8/20/25 (11 weeks/3 days) identified: four bathes give in June, four bathes given in July, and two bathes given in August. During an observation/interview on 8/19/25 at 10:10 a.m., R1 laid in recliner, eyes closed, snoring. Woke up when name was spoken. She stated she received one whirlpool bath a week but would like more and her sister had asked staff for more. Her hair was frequently oily, felt dirty, and she felt embarrassed when she left her room. R1's hair was observed to be shine with an oily, straight and unkept appearance that hung down to her shoulders. During a second observation on 8/19/25 at 12:00 p.m., R1 sat at a dining room table with five other residents for lunch. Her hair again appeared oily, stringy, and unkept. During a third interview/observation on 8/19/25 at 1:38 p.m., R1 laid in bed covered with blankets. Two staff NAs entered the room and transferred her to wheelchair and brought her out to an activity. R1's hair appeared oily, unkept, straight, thin, and hung over her shoulders. During an observation/interview on 8/20/25 at 9:00 a.m., R1 was sitting in the dining room in her wheelchair with one other resident at the table. Her hair appeared oily and unkept. Activities director (AD) sat across the table assisting the other resident and verified R1's hair was oily but added that her hair can occasionally appear like that even after it was washed. Staff were working on trying to give all residents two bathes a week instead of only one. R1 stated she had placed her call light pendent on to let staff know she was ready for her bath. During an observation/interview on 8/20/25 at 9:46 a.m., registered nurse (RN)-D brought R1 into the tub room. She verified her hair was oily, and looked like this every day.			F0676			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0676 SS = E	Continued from page 7 During an observation/interview on 8/20/25 at 12:30 p.m., R1 laid in bed. Hair was brushed and appeared clean and not oily. She smiled and stated she was happy it did not look oily and felt so much cleaner. During an interview on 8/21/25 at 1:05 p.m. NA-A stated R1 received a bath yesterday and hair was washed. Today her hair looked better and clean, but the ends looked a little oily. R1's hair turned oily quickly and she would have benefitted from having her hair washed more often to prevent it from getting oily and looking dirty. R2's quarterly MDS dated 6/27/25, identified she had intact cognition. She had limited ROM lower extremity on one side and used a manual wheelchair for mobility. She required partial/moderate assistance with sit to lying and lying to sitting, and upper body dressing, substantial/maximal assistance with shower/bathing, toileting/personnel hygiene, lower body dressing, roll left and right, sit to stand, and all transfers. Diagnoses included above the right knee amputation, DM, anxiety, and depression. R2's care plan dated 7/5/25, identified a self-care deficit with ADL's: bathing and personal hygiene. She will be clean and well groomed. She required extensive assistance of one with bathing one time a week on Wednesdays. R2's NA care sheet undated identified bath day Wednesday and Saturday. R2's Bath Schedule for the week of 8/17/25 through 8/23/25, identified bath day as Monday a.m. R2's progress notes from 6/1/25 through 8/18/25, identified skin assessments were completed and no documentation of a bath: 6/3/25, 7/16/25, 7/21/25, 7/26/25, 8/11/25, 8/12/25, 8/18/25. R2's progress notes from 6/1/25 through 8/18/25, identified skin assessments and bath was given: 6/18/25, 7/5/25, 7/9/25, 7/23/25 at 9:43, 7/30/25		F0676				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0676 SS = E	Continued from page 8 R2's weekly skin check documents from 6/1/25 through 8/20/25, were not completed (see above progress notes for skin assessments completed). R2's POC NA documentation from 6/1/25 through 6/30/25, identified a tub bath was given on 6/4/25 and 6/24/25. R2's POC bath documentation for July and August 2025 and was requested but not provided. Summary of documented bathes/showers from 6/1/25 through 8/20/25, (11 weeks/3 days) identified: three bathes were given in June, four bathes given in July, and documentation provided was reviewed and identified no bathes given for August. During an observation/interview on 8/20/25 at 1:25 p.m., R2 was in her wheelchair sitting in her room. Hair appeared clean and uncombed. R2 stated she had requested two baths a week but was scheduled for one and her bath was scheduled for Wednesdays. She felt so much better when she was clean. There had been times when she had gone two to three weeks without a bath and had turned down a bath on a Monday, then staff did not have time to get her in again on Thursday or Friday, indicated she thought that was her fault when staff had not come back and offer her another bath that week. She needed her hair washed or it felt uncomfortable, her scalp itched, and her hair looked unkept. She was embarrassed and did not feel good about herself when that happened. She usually had company on the weekends and wanted to look nice when she was visiting friends and family. R3's annual MDS dated 4/4/25, identified intact cognition. She had impaired ROM lower extremities bilaterally and used a manual wheelchair for mobility. She required substantial/maximal assistance with shower/bathing, upper/lower dressing, roll left/right, and personal hygiene, dependent for sit to lying, toileting hygiene, all transfers, and unable to walk. Diagnoses included DM, multiple sclerosis (MS) (causes breakdown of the protective covering of nerve and can cause numbness, weakness, trouble walking, vision changes, and other symptoms), and depression.		F0676				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0676 SS = E	Continued from page 9 R3's care plan dated 7/7/25, identified self-care deficit related to MS, obesity, and muscle weakness. She will be clean and well groomed. She required extensive assist of one for all bathing activities. When in tub chair with seat belt properly attached was allowed to sit in bath independently. She enjoyed soaking in tub for long periods of time. Bath days were Monday and Thursday. R3's NA care sheet undated also identified bath days as Monday and Thursday. R3's Bath Schedule for the week of 8/17/25 through 8/23/25, identified bath days as Sunday and Thursday a.m. R3's progress notes from 6/1/25 through 8/18/25, identified skin assessments were completed and no baths identified: 6/2/25, 6/9/25, 6/16/25, 6/23/25, 7/7/25, 7/14/25, 7/21/25, 7/27/25, 8/4/25, and 8/11/25. R3's weekly skin checks from 6/1/25 through 8/20/25 identified a bath/shower was given: 6/9/25, 6/23/25, 7/7/25, 7/21/25 (bed bath), 8/4/25 R3's POC NA documentation from 6/1/25 through 8/20/25, identified a shower or bed bath was given: 6/9/25, 6/16/25, 7/21/25 (bed bath). Summary of documented showers/bathes from 6/1/25 through 8/20/25 (11 weeks/3 days): three bathes given in June, one shower and one bed bath given in July, and one bath given in August. During an observation/interview on 8/19/25 at 3:45 p.m. R3 sat in her wheelchair in her room. She appeared well groomed with clean hair. R3 stated she was supposed to receive a shower/bath twice a week but they had staff leaving and the bath aide was removed from her position and placed on the floor as an NA. Her bath was scheduled for Monday but had received her last bath on Friday. One day her granddaughter came to visit and thought her hair was still wet from a shower when it was just oily. R3 indicated she was very embarrassed. She hates the hair cleaning bags, they do not clean the hair. She felt it was very difficult to go an entire week without her hair being washed, it was so painful.		F0676				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community			STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0676 SS = E	Continued from page 10 R3 usually had her hair washed on Monday, Wednesday and Friday then it was changed to twice a week, and never happened, and now only once a week. Other residents bring the lack of bathing up in resident council but, nothing seemed to get resolved. She requested her hair to be washed last night and a staff assisted her with it. She stated she felt cleaner and it felt and looked so much better. R4's quarterly MDS dated 6/13/25, identified intact cognition with verbal behaviors directed towards others (e.g. threatening others, screaming at others, cursing at others) one to three times a week. She required partial/moderate assistance with lower body dressing, substantial/maximal assistance with personal hygiene, shower/bathing, sit to stand, all transfers, and walk 150 feet in corridor. She used a walker and manual wheelchair for mobility. R4's care plan dated 6/27/25, identified a self-care deficit with ADLs: bathing and personal hygiene. She would be cleaned and groomed. She required one assist with bathing up to two times a week. R4's NA care sheet undated bath day not identified. R4's Bath Schedule for the week of 8/17/25 through 8/23/25, identified bath day Tuesday a.m. R4's progress notes from 6/1/25 through 8/21/25, identified: -6/4/25 at 6:04 a.m. writer gave a quick bath. She was upset because she was not allowed to soak for a long time. Writer explained to resident that we are only required to give a shower/bath and that out of kindness they did extras when they had time. -6/4/25 at 9:41 p.m. bath noted -6/9/25 at 10:22 a.m. resident obsessed with her hair and makeup. Reported she did not get a good enough bath last week and wants one from a specific NA today. Very upset and obsessed over it. Hard to redirect. -6/12/25 at 11:38 a.m. Resident wanted two bathes per week and staff are aware. She had refused bathes unless she had a specific staff. -6/14/25 at 1:16 p.m. resident upset, housekeeping	F0676		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0676 SS = E	Continued from page 11 staff was not able to cut hair or do makeup. Reminded housekeeping responsibilities do not include those tasks. Floor staff were unable to help cut her hair today and she applied her own makeup. -6/21/25 at 7:36 a.m. received bath per her request. -6/30/25 at 10:01 a.m. discussed at interdisciplinary team (IDT) meeting: behaviors- wanted her hair done right away and stated roommate takes priority over her. 7/9/25 at 1:30 p.m. Resident upset due to NA not having time to do her hair and makeup after her bath, informed several times she would need to wait until they had time or schedule with beauty shop. -7/9/25 at 3:18 p.m. resident stated her bath was terrible due to bath was not given by the normal bath aide, hair, and makeup were not done. Stated she could not wait for bath aide to get back to her own job. -7/15/25 at 11:25 p.m. resident had a bath per her request. -8/6/25 at 6:26 p.m. resident had bath. -8/12/25 at 2:57 p.m. offered her bath multiple times and she had refused and stated later. Passed onto oncoming shift she still needed a bath. -8/19/25 at 10:51 a.m. Bath not received today due to bath given on Sunday 8/17/25, hair washed and colored. Summary of documented showers/bathes from 6/1/25 through 8/20/25, (11 weeks/3 days) identified approximately one bath a week and occasionally refused. R4 had requested two bathes a week. During an observation/interview on 8/21/25 at 10:30 a.m., R4 sat in her room in a wheelchair. Her hair appeared clean, uncombed and bangs hung in her eyes. R4 stated she was scheduled for a bath Tuesday and Fridays but did not receive her bath on Tuesdays. She never knew when she was getting her next bath, it seemed like it was whenever they felt like it. She had received a whirlpool bath yesterday and it was so wonderful. She wanted two bathes a week and has not received more than one. Her hair had been oily, itchy, and felt dirty before the week was up. Looking nice, with hair fixed and make up on was important to her, she had worked in a court room years ago, dressed up and had to look decent. She had taken great pride in looking well kept.			F0676			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0676 SS = E	Continued from page 12 She felt terrible with the way hair looked today, her bangs hung in her eyes, and not styled. There was no beauty shop here to fix her hair and the staff were too busy. She was embarrassed and stated "how would you feel gong out looking like she did today with her hair not styled and messy looking?" During an interview on 8/19/25 at 12:13 p.m. NA-C stated the general goal was to have provided two bathes a week for each resident. Depending on staff's wiliness to go that extra mile and work hard they can get two done a week for each resident. There had been times residents had not received one bath a week due to staff refusing to give them. The bath aide was pulled due to low census and some NAs had refused to complete the resident bathes. Management was aware and currently working on it. The nurse documented the bathes when they charted their weekly skin assessments. The residents had complained they were not receiving their baths. There were days when she worked the medication cart and still assisted with bathes so that they would get done. Bathing was important to make sure residents had clean hair/skin and felt good. During an interview on 8/19/25 at 2:24 p.m., RN-C stated we no longer have a bath aide due to low census. The staff were expected to try and get two bathes a week completed for each resident. There was a document at the nurse's station and tub room with a list of a.m. and p.m. resident bathes. She directed staff to get the bath completed as a team, depending on the staff working they took the initiative, and got the job done, but sometimes not all resident received their bathes. There were NAs that refused to complete the resident bathes for the past two months and management were aware. During an interview on 8/19/25 at 2:41 p.m., NA-A stated there was not enough staff or time in the day to get two bathes done in a week for all residents. In the past couple of weeks, the resident received at least one bath a week but prior to that they were lucky if they received one. The weeks they had not receive a bath staff tried to wash them the best they could. NAs were expected to document in POC on the electronic medical record each time the resident received a bath. There was no consistency in the documentation and was hard to track whether they received a bath or not. Staff were expected to document when a resident refused a bath. There were at least three residents that complained they had not received their bath when the		F0676				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0676 SS = E	Continued from page 13 bath aide was gone for a day or sick. The bath was skipped and not completed by the staff working. During an interview on 8/20/25 at 11:00 a.m., director of nursing (DON) stated all bathes had been done in the a.m. when we had a bath aide. The bath aide was removed, and bathes were not being completed as scheduled on all residents so she changed the schedule for bathes to be completed on a.m. and p.m. shifts. There was an audit completed by nursing about one month ago, the residents were asked how many bathes a week they preferred. The bathes were getting done more often however some staff refused to give the bathes and we are working on holding them accountable. The bath aide was removed from her assigned area and scheduled as an NA on the floor. The nurse would be expected/responsible to document in the progress notes each time a resident received their bath. The staff bathing documentation had not been reviewed and/or audited. Bathing was important for all resident for personal hygiene and dignity. During an interview on 8/20/25 at 2:30 p.m., NA-B stated there were some residents that had requested two bathes a week and were not getting them. We are told to make time for them but hard to know how to prioritize our assignments/tasks for sure. She stated R1's hair looked oily and dirty earlier today. Additionally another resident, R2 had informed her she wanted her hair washed and a bath due to family coming to visit. During an interview on 8/21/25 at 1:07 p.m., RN-B manager stated all residents should have received at least one bath a week and the nurse was expected to have completed a weekly skin assessment and/or a weekly skin assessment progress note and identify when a bath was given. There were times when the NA marked the bath sheet at the nurse's station and those were filed, unsure as to how long. The staff were expected to take responsibility for the weekly baths and the documentation of them so that it could be tracked easily and assure they were completed. Bathing was important for personal hygiene/skin and if hair was oily could have possibly affected their dignity. Had not heard of any residents complain of lack of bathing, only a family member. Resident council meeting minutes dated 7/8/25, identified nursing concerns/comments: residents were wondering why they can't have more than one bath a		F0676				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community			STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0676 SS = E	Continued from page 14 week. R2 expressed she was not getting one bath a week. No indicated follow up. Resident council meeting minutes dated 8/12/25, identified nursing concerns/comments: [R2] had not received her bath on her scheduled bath day. She spent all day in a night gown and wanted to know if she would be receiving a bath. No indicated follow up. Facility policy Activities of Daily Living dated 2021, identified the facility associates will be expected to provide care and services to residents unable to carry out ADL's independently necessary to maintain good nutrition, grooming, personal hygiene, elimination, communication, and mobility. Those services include but are not limited to: hygiene (bathing, dressing, grooming and oral care). If a resident refused cares, the response will be documented and associates will approach at a different time, or have another associate speak with the resident as needed.	F0676		
F0688 SS = E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide restorative services for 4 of 4 residents (R1, R2, R3, R4) who discharge from Physical Therapy services with maintenance orders to maintain range of motion and conditioning. This had the	F0688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community			STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0688 SS = E	Continued from page 15 potential to affect all 21 residents care planned for restorative therapy. Findings include: R1's quarterly Minimum Data Set (MDS) dated 5/16/25, identified she had intact cognition and no behaviors. She had impaired ROM upper and lower extremities bilaterally and used a walker and wheelchair for mobility. She was dependent to roll left and right, sit to lying, lying to sit, sit to stand, and all transfers, and substantial/maximal assistance to walk 10 feet, personal/toilet hygiene, and upper/lower body dressing. R1's care plan dated 5/20/25, identified activities of daily living (ADL) deficit and required restorative active range of motion (AROM): required passive range of motion (PROM) to left upper extremity three to six days a week. Staff were directed to complete PROM – shoulder flex, should abduction, elbow flex/extension, forearm supination (the forearm is rotated with assistance so the palm of hand faced upwards/prn (as needed) wrist flexion/extension. Ten reputations times one set up to six days a week once a day. She was unable to walk alone due to history of stroke and required restorative therapy: left knee brace, gripper socks, gait belt, right hand along the hallway railing, support under her left arm, followed with wheelchair with 25 feet at a time, up to two to three tries. She required AROM to upper extremities three to six days a week. Staff (certified nursing assistant/nursing) were directed to follow treatment guideline of occupational/physical therapy. Right upper extremity, two-pound shoulder flex, shoulder abduction, chest press, overhead press, 10 reputations times up to six days a week. R1's nursing assistant (NA) care sheet undated identified ambulation: therapy only. R1's PT discharge dated 2/24/25, identified had made good progress towards goals. Due to severity with cerebral vascular accident (CVA) (stroke) with left hemiplegia (complete or severe loss of voluntary movement on side of the body) she will continue to need assistance with all functional mobility. Continued to present with weakness decreased endurance, impaired balance, and impaired safety awareness. She required assist of one for transfers, bed mobility, and	F0688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0688 SS = E	Continued from page 16 ambulation. She ambulates up to 24 feet with railing, knee brace, and moderate assistance of one. Her transfers were variable from minimum assist to maximum assist due to this nursing staff are using assist of two for transfers and EZ stand lift for toileting. Recommendations discussed with her and/or care giver the needed assist with all functional mobility. She was wheelchair bound for functional mobility. Recommend restorative nursing program (RNP) for ambulation. R1's restorative log dated 6/2/25 through 6/8/25, identified PROM and AROM signed off on 6/3/25, 6/4/25, and 6/5/25. R1's point of care (POC) history documentation for RNP identified: -6/6/25 through 6/30/25, number of days, active range of motion (AROM) was completed 6 out of 25 days. -6/6/25 through 6/30/25, number of days for passive range of motion (PROM) was completed 6 out of 25 days. -6/6/25 through 6/30/25, number of days walking was completed 0 out of 25 days. -7/1/25 through 7/31/25, number of days of AROM was completed 12 out of 31 days. -7/1/25 through 7/31/25, number of days PROM was completed 12 out of 31 days. -7/1/25 through 7/31/25, number of days walking was completed 0 out of 31 days. -8/1/25 through 8/20/25, number of days of AROM was completed 2 out of 20 days. -8/1/25 through 8/20/25, number of days PROM was completed 2 out of 20 days. -8/1/25 through 8/20/25, number of days walking was completed 0 out of 20 days.		F0688				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0688 SS = E	Continued from page 17 During an interview on 8/19/25 at 10:10 a.m. R1 stated she had not received any type of therapy/ROM with her left arm or any part of her boy for quite a while now. She had noted decreased strength and movement in that arm and wanted to check with provider to get an order for physical therapy (PT). R2's quarterly MDS dated 6/27/25, identified she had intact cognition and no behaviors. She had limited ROM lower extremity on one side and used a manual wheelchair for mobility. She required partial/moderate assistance with sit to lying and lying to sitting, and upper body dressing, substantial/maximal assistance with shower/bathing, toileting/personnel hygiene, lower body dressing, roll left and right, sit to stand, and all transfers. R2's care plan dated 7/5/25, identified restorative nursing: she was at risk for reduced mobility related to weakness and amputation of right leg lack of ability to ambulate. Nursing was directed to provide restorative nursing, seated, bilaterally upper extremities AROM with four-pound weight dowel 20 repetitions and downward and backward 20 repetitions up to six times a week. R2's PT notes dated 2/18/25, identified clinical impression: she was ablet o perform all functional transfers with minimum assist. Restorative aide also felt that she had returned to baseline. R2's PT patient's self-report of their current status dated 2/18/25, identified she was discharged from PT on this date due to plan of care (POC) expired and she no longer warrants skilled PT. Will add omincycle to RNP. She chose omnicycle over standing performed for lower extremity strength. Showed restorative aide set up for anchoring left foot it pedal. R2's PT evaluation dated 4/3/25, identified she was referred to PT services due to nursing reported increased assistance with transfers. Restorative nursing coach had been gone and she felt that this was also why she was needing more assistance with transfers. RNP will continue at this time and she felt that she would be ok without PT. She received contact guard assist (CGA) to minimum assist for transfers			F0688			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0688 SS = E	Continued from page 18 to/from wheelchair to bed and toilet transfers, and used wheelchair for all mobility. Recommended she continued with RNP. R2's order dated 7/23/25, PT evaluation and treat. Diagnosis: muscle weakness (generalized). R2's PT evaluation dated 7/29/25, identified she was referred to PT services by primary care provider due to reduction in functional level, requiring skilled serviced to re-condition her back to prior levels. She presented with weakness, endurance and aerobic capacity deficits, impaired balance and greater difficulty in transfers placing her at greater risk for falls. She had right transfemoral amputation and left trans metatarsal amputation. She required skilled intervention to address deficits in upper and lower extremity strength, endurance and aerobic capacity, static and dynamic balance, functional reach and ability to transfer safely and more independently. PT planned frequency: three times a week times 12 weeks. The skilled intervention focus: restoration compensation. R2's progress notes identified: -7/18/25 at 11:27 p.m. transferred poorly and needed extensive assistance of two. She stated she stated last night she had spasms and felt pain more on the left buttock to her hip and requested she wanted to be seen by therapy. -7/22/25 at 6:23 p.m. physician assistant (PA) ordered PT and treat due to decline in transfers. R2's restorative log dated 6/2/25 through 6/8/25, identified AROM and stand 4 minutes signed off 6/3/25 (husband), 6/4/25 (husband), and 6/5/25. R2's POC history documentation for RNP identified: -6/6/25 through 6/30/25, number of days AROM was documented 6 out of 25 days. -7/1/25 through 7/31/25, number of days AROM was documented as completed 10 out of 31 days.		F0688				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0688 SS = E	Continued from page 19 -8/1/25 through 8/20/25, number of days AROM was documented as completed 0 out of 20 days. During an interview/observation on 8/20/25 at 1:25 p.m., R2 sat her room in a wheel chair with a left above the knee amputation fully dressed. She had worked with the restorative aide, he was dependable, saw her daily (5 times a week) and helped maintained her strength. Once he left, she had not received her restorative therapy as care planned and felt it was getting harder and harder to stand up. She got to the point staff had to lift her up more because she was losing strength. She requested therapy during a care conference, was scheduled to return three times a week, and that has helped improve her strength. During an interview on 8/20/25 at 2:30 p.m., NA-B stated restorative therapy ended on 6/4/25, and R2 no longer received it. She saw a decline on how R2's transferred from wheelchair to toilet. She noted the change began the beginning of July 2025 when she required two staff to transfer instead of one safely with a gait belt. R2 told her she was unable to hold her weight on the one leg and had taken longer for her to get her weight up on it while she stood up from the wheelchair with extra help. Prior to the noted decline, she transferred with assist of one and gait belt. She had informed the staff nurse about her increased weakness. R2 verbalized when she had issues with standing, increased weakness had occurred. Approximately three out of six shifts she had worked with her she required assistance of two staff instead of one. R3's annual MDS dated 4/4/25, identified intact cognition without behaviors. She had impaired PROM lower extremities bilaterally and used a manual wheelchair for mobility. She required substantial/maximal assistance with shower/bathing, upper/lower dressing, roll left/right, and personal hygiene, dependent for sit to lying, toileting hygiene, all transfers, and unable to walk. Diagnoses included DM, multiple sclerosis (MS) (causes breakdown of the protective covering of nerve and can cause numbness, weakness, trouble walking, vision changes, and other symptoms), and depression. R3's care plan dated 7/7/25, identified restorative PROM: she was at risk for contractures in bilateral		F0688				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0688 SS = E	Continued from page 20 lower extremities related to multiple sclerosis as evidenced by weakness, inability to move lower extremities with assist, obesity, and chronic pain. Restorative staff will help her with PROM stretch to bilateral hips, knees, ankles, toes in all motions with or without ceiling trance sling up to five times a week. R3's restorative log dated 6/2/25 through 6/8/25, identified PROM signed off 6/3/25, 6/4/25, and 6/6/25. R3's POC history documentation for RNP identified: -6/6/25 through 6/30/25, number of days PROM was documented 9 out of 25 days. -7/1/25 through 7/31/25, number of days PROM was documented 9 out of 31 days. During an interview on 8/19/25 at 3:45 p.m., R3 stated she had not received her restorative therapy since the restorative aide left and moved away over two months ago. She had MS, her legs and feet do not work and required PROM to be completed by someone. She stated it was included in her care plan and the restorative aide completed her therapy at least three to four times a week. The therapy felt so good while her legs were stretched. The agency staff ask me to move my feet and they are unaware she could not do that. She had hoped to get some strength and movement back in her lower extremities. R4's quarterly MDS dated 6/13/25, identified she had intact cognition with verbal behaviors directed towards others (e.g. threatening others, screaming at others, cursing at others) one to three times a week. She required partial/moderate assistance with lower body dressing, substantial/maximal assistance with personal hygiene, shower/bathing, sit to stand, all transfers, and walk 150 feet in corridor. She used a walker and manual wheelchair for mobility. R4's care plan dated 6/2/25, identified restorative nursing: she was at risk for further decline in AROM of bilateral upper extremities and bilateral lower extremities to fracture of right femur with surgical repair, history of traumatic subdural hemorrhage with		F0688				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0688 SS = E	Continued from page 21 loss of consciousness, chronic pain syndrome as evidenced by muscle weakness and history of falling. Staff were directed to have provided, monitored, and documented he participation in the restorative program up to six times a week. The program was to have included bilateral upper extremity exercised using two-to-three-pound weights, two sets of 15: biceps curl, chest press, shoulder flexion, shoulder horizontal abduction and adduction. Bilateral lower extremity three-pound weight, front wheeled walker, standing, marching, kick forwards, hip abduction, ankle plantarflexion, hip extensions, 15 to 20 reputations. R4's new rehabilitation orders dated 5/22/25, identified RNP: bilateral upper extremity AROM should flex and abduction, AROM elbow flex/extension, finger flex/extension or arm bike (right upper extremity only) at level three for 15 minutes. Gait with front wheeled walker, grab bar, close wheelchair, follow distance as tolerated up to 40 degrees, omnycycle, bilateral lower extremities 15 minutes, level 5 to 7. R4's PT discharge 5/28/25, identified she had made minimal progress during therapy sessions. She had a decline following evaluation and then some improvement again following the decline. She had most likely met her new bassline/maximum potential. Discharge plan: recommendations included RNP for lower extremity strengthening and ambulation. R4's restorative log dated 6/2/25 through 6/8/25, identified AROM signed off 6/2/525 and 6/5/25. R4's POC history documentation for RNP identified: -6/6/25 through 6/30/25, AROM was documented 9 out of 15 days. -6/6/25 through 6/30/25, walking was documented 1 out of 15 days. -7/1/25 through 7/31/25 walking was documented 3 out of 31 days. -8/1/25 through 8/21/5, walking was documented 0 out of 21 days.		F0688				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0688 SS = E	Continued from page 22 R4's PT evaluation/assessment dated 6/27/25, identified she experienced a fall in her room and found sitting on buttocks. She had generalized weakness and deconditioning leading to difficulty with ability to ambulate and perform functional mobility tasks. She required skilled PT services to assess functional abilities, promote safety awareness, increase functional acidity tolerance and independence with gait. Skilled intervention focus: restoration. Plan of treatment PT five times a week for 12 weeks. During an interview on 8/21/25 at 10:30 a.m., R4 stated the restorative aide was so good and she really missed him. He worked with her frequently and helped her maintain her strength, never afraid to say let's walk. One day he disappeared. At that time she was able to walk with a walker, and had benefited from restorative but once he left, she became weaker and found it harder to transfer out of wheelchair to the toilet. R4 stated about 6 weeks ago she did not place her call light on, self-transferred against her own better judgement, fell in her room and required PT. During an interview on 8/19/25 at 2:41 p.m., NA-A stated restorative aide was no longer here and believed activities staff were to be assigned the therapy but had not seen staff completing the restorative therapy since the previous aid left over one month ago. Restorative therapy was needed to provide those services to residents to keep their strength and moving. We have become an institution instead of a home for these residents and had some residents that just sat all day long without anyone working with them to maintain their strength. During an interview on 8/19/25 at 2:45 p.m., registered nurse (RN)-C stated there used to be a restorative aide and he had left. Unsure if the restorative therapy was being completed, how it was being monitored, and who oversaw it now. Could have been discontinued due to low resident census. During an interview on 8/20/25 at 10:30 a.m., medical doctor (MD) stated she assumed R1 was receiving her restorative therapy. PT was ordered for her today per her request. Restorative therapy was important and all residents living at the facility required some type of intervention such as exercises.		F0688				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0688 SS = E	Continued from page 23 During an interview on 8/20/25 at 10:42 a.m. manager RN-A stated the restorative therapy program ended on 6/4/25. R1 had not received restorative therapy as care planned, was elective, and not required. Unsure if it had been offered to her. Restorative therapy helped residents with their overall mobility, potentially prevented skin issues, improved quality of life, and maintained the abilities they already had. During a combined interview on 8/20/25 at 11:00 a.m., director of nursing (DON) and administrator indicated the facility restorative program ended on 6/4/25. DON stated she was unable to find the restorative book previously used by the restorative NA after he left. Orders for those residents noted to need therapy had been placed. Today there was an ordered placed for R1 to be assessed for PT. Administrator stated the facility therapy department gave notice and exited. We brought in a contracted therapy program on 6/2/25, they did not offer a restorative program. In place of restorative therapy, we offered daily activities such as moves and groves schedule by activities. We lacked time and were unable to come up with a new restorative plan. Those residents currently care planned for restorative therapy would require audits to be completed, restorative program removed from the care plan and that piece was missed. Administrator stated a new program needs to be designed, NAs educated, and all that takes time. Restorative therapy was important for residents to receive, helped maintain the level they have achieved through PT. Those residents care planned to have received restorative and unable to verbalize and/or move themselves would benefit from restorative therapy to keep muscles active and maintain their mobility. DON stated we planned on getting back on track and offer restorative with staff required training. During an interview on 8/20/25 at 12:37 p.m., PT-A stated restorative therapy was important for all residents to maintain their mobility and keep them moving, avoid laying/sitting in their rooms, promote the highest functional ability, and helped alleviate pain. R3 had MS and would be important for her to have received restorative therapy. MS was a progressive disease and she became fatigued easily. During a follow-up interview on 8/20/25 at 4:00 p.m., PT-A stated R2 was minimum assist of one for sit to			F0688			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0688 SS = E	Continued from page 24 stand on 4/3/25, and she was currently assessed to be moderate assist of one. All her transfers were currently moderate assist, stood one to three minutes/bar supported, tired quickly and got fatigued. There was a noted decline in her sit to stand and transfers from minimum to moderate assist due to loss of strength to get herself up. Restorative therapy program and increase strengthening of her upper extremities would have helped maintain and strengthen her upper extremities if she would have received the therapy according to her care plan. Resident's buy in and attitude would have made a difference and helped maintain her functional abilities. During an interview on 8/21/25 at 10:12 a.m., PT-B stated therapy services were taken over by a different company early June 2025. We were told the facility would get restorative by 7/1/25 and had not started yet. Restorative would be very helpful for the residents to assist with maintaining strength/endurance and lessen the need for acute therapy. During an interview on 8/1/25 at 12:22 p.m., regional director of clinical services (RD) stated R2 had back and forth of weakness even with restorative that could have been caused by other reasons such as increased hip/spasms, buttock pain, change in a decrease in medication (Buspar) (antianxiety), and low blood sugars. The change in RTP should have been communicated differently and been replaced. Unsure if that was communicated effectively. The administrator sent out a letter to the residents and resident council for other options. She did not think other options had been initiated. A detailed plan was needed to roll out the new restorative program. During a combined interview on 8/21/25 at 1:07 p.m., RN-B manager and DON were seated in an office. RN-B stated they had planned on moving restorative tasks to activities. DON stated activities assisted only one resident so far with ambulation. The restorative therapy had not been performed as care planned since June 4, 2025, and planned on getting reorganized, until then the residents had a daily exercising group with activities. RN-B stated R2 had a decline in her strength/mobility starting early spring when she gained weight, struggled with clothing that did not fit well, and mental /emotional/physical concerns. R2 requested PT on 6/23/25, needed more help with transfers. DON stated R2 required more assistance with range of motion.			F0688			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245502		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0688 SS = E	Continued from page 25 Resident council meeting minutes dated 6/10/25, identified nursing concerns/comments: worried about not having help with ROM. Going to investigate ways to get residents moving that had the restorative program. Resident council meeting minutes dated 8/12/25, identified nursing concerns/comments: wishing there was a restorative program. Per email received from DON on 8/20/25, identified 21 residents currently care planned for restorative nursing program. Six of those residents were recently assessed by PT. Facility policy Restorative Nursing Program dated 10/4/23, identified the purpose of the restorative nursing program was to promote an optimal level of physical, mental, and psychosocial functioning in alignment with a resident's individual goals. The program can promote resident's highest level of independence in each of the following areas: eating and swallowing, activities of daily living, splints/braces, range of motion (ROM), ambulation, amputation/prosthesis care, communication and bed mobility. The registered nurse will complete an assessment of restorative functioning for new admissions, readmissions, and upon a significant change in status and in collaboration with therapist, the resident, responsible party or other designated facility associate will design the individual restorative nursing program for the resident. Associates administering the restorative interventions will be trained and competencies on the interventions that may be assigned to them. A RN will provide oversight to the program to ensure the restorative interventions are being implemented as planned and document at a minimum the program evaluation indicating the progress, and changes to the restorative care plan. Changes will be shared with staff via communication forms. If a resident has improved or declined, therapy should re-evaluate the resident and revise the plan as indicated in collaboration with the RN.		F0688				

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
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 8/19/25 through 8/21/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaint was reviewed during the survey.		20000				

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
20000	Continued from page 1 H55021481C (2579534) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		20000				