



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 Therefore, the NATCEP prohibition is rescinded.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



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December 24, 2025

Administrator
Benedictine Care Community

201 9TH STREET WEST
ADA, MN 56510

Re: Reinspection Results
Event ID: 1D7697H1

Dear Administrator:

On November 7, 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
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October 16, 2025

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

Re: State Nursing Home Licensing Orders

Event ID: 1D7697-H1

Dear Administrator:

The above facility was surveyed on September 25, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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

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

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



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October 16, 2025

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

RE: CCN: 245502

Cycle Start Date: August 21, 2025

Dear Administrator:

On September 10, 2025, we informed you that we may impose enforcement remedies.

On September 25, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance.

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby 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 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), October 31, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 31, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 31, 2025.

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 , the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Benedictine Care Community will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from . 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)

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by 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 Steven Delich, Program Representative at (312) 886-5216. 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,

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

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 09/25/2025	
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 9/19/25, 9/24/25, and 9/25/25, 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 complaint was reviewed H55024293C (2614476) with a deficiency cited at F684. Deficient practice was identified related to incidental finding at F580. 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			10/17/2025	
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical		F0580	During the complaint survey process, it was noted that the facility failed to promptly notify a physician of a change in condition for R1. R1's physician was notified on 9/4/2025 along with the resident's representative on 9/4/2025 date. Resident's care plan was reviewed on 9/10/2025 and remains current. Physician was in to see resident on 9/11/2025 to complete recert. Progress notes have been reviewed from 9/10/2025 to current and no other untimely notifications were identified. All residents have the ability to be affected by this deficient practice. A review of progress notes since the date of the complaint survey 9/25/25 to present were reviewed for all residents and no other incidents of untimely notification were identified for any other residents.		10/27/2025	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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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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 09/25/2025	
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	
F0580 SS = D	Continued from page 1 complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to promptly notify a physician of a change in condition for 1 of 3 residents (R1) reviewed when a left hip surgical incision showed signs of infection and required hospitalization. Findings include:		F0580	Continued from page 1 A new facility policy on notification of changes was approved on 10/16/2025 and education was provided to all associated staff on the new policy and incidents to which could potentially prompt notification to a physician on 10/17/2025. Audits will be conducted through the review of progress notes 5x a week to review for any changes in condition and timely notification for all residents x 4 weeks. Then the audits will go down to 3 days a week for all residents x 8 weeks and as needed thereafter as determined by quality council for continued compliance. DON/DON designee are responsible for compliance.			

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 09/25/2025	
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F0580 SS = D	Continued from page 2 R1's hospital discharge summary dated 8/1/25, identified mechanical ground level fall after losing her balance and sustained a left subtrochanteric femur fracture. She required surgery that included an ORIF and tramedullary nailing of left femur. Surgical incision noted to left hip with dressing. R1's progress notes from 8/26/25 through 9/10/25, identified: -8/26/25 at 1:42 p.m. Skilled Nursing Documentation: Surgical wound left hip/thigh, no drainage, surrounding tissue intact and no pain. Nursing Interventions: surgical wound care. -8/26/25 at 8:33 p.m. Staples to left hip/thigh removed per order. R1 tolerated well. Cleansed area with saline and applied steri strips. -8/27/25, 8/28/25, 8/29/26, 8/30/25, Skilled Nursing Documentation completed. No documentation in progress notes on left hip/thigh incision (4 days). -9/1/25 at 8:43 a.m. Surgical wound left hip scant amount of purulent (thick and milky discharge from a wound and almost always indicates an infection, should not be ignored, and needs treatment as soon as possible) drainage. Surrounding tissue erythema (redness that occurs when extra blood rushes to an area and often indicates inflammation or infection). Pain was present with tenderness to upper aspect of incision. Nursing interventions: proper positioning and surgical wound care. -9/1/25 at 8:43 a.m. Skin Assessment: Skin check done prior to shower. Surgical incision to left hip is read and warm to upper half of incision. R1 does report some tenderness to area. Scant purulent drainage noted to two areas of upper incision: bottom area measuring 1.3 centimeters (cm) along incision and top area measuring 3 cm along incision. Cleansed with wound wash and patted dry. Waterproof surgical post op bandage applied. -9/1/25 at 11:59 a.m. as needed (PRN) Tylenol given at 12:00 p.m. per her request for pain. -9/1/25 at 2:19 p.m. Surgical wound left hip scant amount of purulent drainage, surrounding tissue erythema, and no pain. Interventions to promote healing and prevent infection: proper positioning and surgical wound care.			F0580			

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 09/25/2025
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F0580 SS = D	Continued from page 3 -9/2/25 at 2:19 p.m. surgical wound left hip scant amount of purulent drainage, surrounding tissue erythema, and no pain. Interventions used to promote healing and prevent infection: positioning and surgical wound care. -9/3/25 at 4:07 p.m. R1 had red and warm to touch right foot/toes. Charge nurse sent picture to primary provider medical doctor (MD) who ordered Bactrim double strength (DS) two times a day (BID) times 7 days. Orders updated. -9/3/25 at 11:18 p.m. Skilled Nursing documentation completed. Skin and/or left hip incision was not included in this entry. -9/4/25 at 6:24 p.m. Nurse was asked to check left hip as was noted to be read and swollen today with pain. Started on Bactrim yesterday. Area or [sic] erythema and edema marked earlier. There was a Meplix surgical in place with 430% [sic] serous drainage present to foam. The area marked has not spread and is 37 x 34 cm. There is a peau d [sic] orange skin texture. Skin is warm and erythematous. R1 reported it throbs and aches. Temperature 100.0 (F). Report sent to MD. Further vitals checked at within proximity to last check. No response from MD yet. Did report to oncoming nurse no response yet and encouraged to monitor vitals more frequently throughout the evening. Told R1 she may need an evaluation through the hospital and possible increase in antibiotics and she said no. When asked further she stated she did not wish to go to the hospital. She was informed a message was sent to the provider and that they would continue to monitor. Instructed to report feeling of chills or sweats. -9/4/25 at 7:11 p.m. MD responded thinking of a resident transfer to higher level of care. Awaiting orders for transfer to local ER vs another hospital. R1 agreed with transfer stated, "if she had to". Nurse on duty was aware of pending transfer. Hand off report had been given. -9/4/25 at 7:28 p.m. R1 was transferred to local hospital via son. Bed holds in place. -9/5/25 at 8:43 a.m. Discussed at interdisciplinary team (IDT): transferred to local hospital due to worsening of infection of left hip. -9/10/25 at 10:55 a.m. R1's planned arrival date back to facility 9/10/25 around 11:30 a.m. to 12:00 p.m. Admission diagnoses: sepsis due to post surgical	F0580		

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 09/25/2025	
NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
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F0580 SS = D	Continued from page 4 abscess. Cares: peripherally inserted central catheter (PICC) (a long flexible catheter goes into your upper arm vein, through the vein in the arm and into a large vein located by the heart and allowed for long term access to infuse IV fluids, medications, and draw blood) line/antibiotic (Abx) for six weeks and wound vac/Prevena (not to be removed until batteries die) left hip. -9/10/25 at 12:35 p.m. R1 admitted from hospital in stable condition. -9/10/25 at 4:22 p.m. Skin assessment: left hip incision swollen and redness noted with wound vac in place. Left posterior calf open area 4 x 1 cm and 0.5 cm deep with clear drainage. Meplix dressing over Silvadene gauze ordered. R1's admission to hospital dated 9/5/25, identified admitted to hospital for post-surgical abscess and overlying abscess or previous left subtrochanteric femur fracture due to ground level fall status post ORIF with intramedullary nailing of left femur. Sepsis and increased left hip pain was due to the above. Orthopedics consulted, plan for surgery in a.m. Given her sepsis started on IV antibiotics Vancomycin and Rocephin. Today brought in by her son as over the last several days had noticed around her incision drainage and redness. Has noted a yellowish color to the drainage. Fever developed over the last 24 hours. She is also noted pain had increased in the left hip over the past few days to the point where she was unable to walk. It sounded like prior to this she was doing well. In the emergency department (ED) she had chills along with a fever of 100.0 degrees Fahrenheit (F), heart rate 114. Lab work completed shower elevated white blood cells (WBC) of 13.4 with left shift, stable hemoglobin, elevated C-reactive protein (CRP) (measures level of a protein in your blood that indicates inflammation) of 166 milligrams per liter (mg/L) (normal range less than 2.0 mg/L) and elevated erythrocyte sedimentation rate (ESR) (measures inflammation in the body) of 67 millimeters per hour (mm/hr.) (normal less than 30). CT scan showed abscess. Notable erythema over the proximal medial thigh extending over the lateral thigh midway down with increased erythema pronounced on the incision site. A bacterial culture with gram stain (laboratory test that helped diagnose harmful bacteria) of the left thigh tissue on 9/5/25, identified a rare staphylococcus aureus (a bacterial infection that can cause serious illness and become deadly if found in the blood stream, joints, bones, lungs, or heart, moderate white blood		F0580				

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F0580 SS = D	Continued from page 5 cells and treated with antibiotics), moderate white blood cells (WBC) (body produces more to fight an infection by attaching and destroying invading pathogens), and many red blood cells (RBC). A bacterial culture with gram stain dated 9/5/25, specimen taken from deep left thigh fluid identified rare staphylococcus aureus and corynebacterium aurimucosum (a nosocomial (occur in healthcare settings) pathogen infecting hard-to-heal peripheral wounds, such as skin wounds, soft tissue abscesses and osteomyelitis) and many WBC. R1’s care plan dated 9/10/25, identified at risk for skin alteration of skin due to limited/decreased mobility and pain. Staff were directed to observe skin integrity daily with cares, bathing, report any reddened, irritated, bruised or open areas and any new skin concerns taken to the nurse to address. R1’s 5-day Minimum Data Set (MDS) dated 9/16/25, identified she was admitted on 8/4/25, hospitalized, and readmitted on 9/10/25. Cognition was intact with no behaviors. Diagnoses included fracture of the hip, peripheral vascular disease (PVD) (narrowed blood vessels reducing blood flow to the limbs), chronic obstructive pulmonary disease (COPD), surgical site incision infection, and cellulitis to right lower limb. R1’s orders from 8/1/25 through 9/13/25 identified: -8/3/25, leave occlusive dressing intact for: comments-keep Prevena (purple) dressing in place until wound vac dies. Remove and throw away. Replace with Mepilex. Change every 7 days with occlusive dressing. If incision is draining, ok to change dressing sooner. Keep covered until staple removal at 2 weeks pos-op. Nursing communication: if she is doing well, ok to remove staples at 2 weeks post-op at skilled nursing facility (SNF) and cancel follow-up appointment. -8/3/25, ice to affected area: ice to lower extremity, cold packs as needed for swelling a pain. Alternate 20 minutes on and 20 minutes off. Assess skin every 2 hours. Do not apply directly to skin. -8/19/25, change Mepilex dressing daily to left hip. May shower, cover incision with waterproof dressing so it does not get wet. -8/26/25, ok to remove staples on 8/26/25 if no drainage. If concerns call orthopedics.		F0580				

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F0580 SS = D	Continued from page 6 -9/10/25, cefazolin (Ancef) (antibiotic) 2,000 milligrams (mg) in sodium chloride 0.9%/50 millimeters (ml) administer IV every 8 hours for post op infection. R1's Hospital Discharge Summary dated 9/8/25, identified two days prior to admission to hospital she was noted to have redness and drainage at incision site. She was admitted to the hospital for surgical cellulitis, orthopedic surgery and infectious disease physician was consulted. Her intraoperative culture showed Morganella Morganii (an unusual opportunistic pathogen belonging to the enterbacteriaceae (microorganisms that can grow in absence of oxygen such as gram-negative) family, primary associated with post-operative wound and urinary tract infections and known for its resistance to multiple antibiotics and evolving virulence. This bacterium often results in a high mortality rate with some infections) and a few peptoniphilus species (gram-positive, anaerobic (requiring absence of free oxygen) causes infections). She had been treated with broad-spectrum IV antibiotics during hospitalization and recommended to complete 6 weeks course of antibiotic discharging on IV Ertapenem per infectious disease physician recommendation. She also received wound VAC during this hospitalization and orthopedic surgery recommended to keep in place for 7 to 14 days or until battery dies, then place Mepilex over incision. Interagency Handoff Report dated 9/10/25, identified R1 was admitted to the hospital on 9/4/25, hospital events: presented to emergency department (ED) with complaints of left hip skin changes and drainage from surgical incision. ORIF of left hip with intramedullary nail placement on 7/29/25. Computerized tomography scan (CT) (imaging test that uses x-rays and a computer to create detailed pictures of your organs, bones, and tissues), showed large fluid collection. Intravenous (IV) fluids and antibiotics administered, orthopedics consulted, planned for incision and drainage (I&D) (procedure to drain pus from an abscess and clean it out to promote healing) tomorrow. Blood cultures completed. PICC (a long flexible catheter goes into your upper arm vein, through the vein in the arm and into a large vein located by the heart and allowed for long term access to infuse IV fluids, medications, and draw blood). During an interview on 9/19/25 at 10:08 a.m. R1 stated her left hip incision was healing pretty good, stitches		F0580				

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F0580 SS = D	Continued from page 7 were taken out but had a hard time when the nurse attempted to remove the two top stiches. The NA saw my incision was getting red on my upper thigh and told then nurse. She had also informed the nurse it was red, increased pain and drainage after the stiches came out. She had to be sent into ER, started on antibiotics and surgery to open it up twice to see where the infection was located. During an interview on 9/19/25 at 2:15 p.m. licensed practical nurse (LPN)-A stated after the staples were removed on 8/26/25, from R1's left hip incision there were two spots at the top of the incision that had a scant to moderate amount of bleeding and small amount of redness. She had cleaned it with warm mild soap, water and applied Mepilex dressing over it to catch the blood daily. On 9/1/25, R1 was more tender with purulent drainage noted at the top of the left hip incision whereas she did not have pain prior. She may have talked to the director of nursing (DON) that day, but nothing was documented so unsure. Usually with an incision that looked like this one on 9/1/25, could have indicated infection, a registered nurse (RN) should have been informed, assess it, and notified provider. Pictures could have been taken, sent to provider, and antibiotics ordered. The nursing assistants informed her a couple of times two days in a row it looked red, unsure which days those were, and she neglected to document it. R1's incision should have been reported to the provider on 9/1/25 or at least by 9/2/25 and was not documented. During an interview on 9/19/25 at 2:51 p.m. nursing assistant (NA)-A stated R1 had a one-inch-wide dressing on her left hip incision and redness was seen around the incision /dressing two days before she was sent to the hospital. She had informed the nurse both days. During an interview on 9/24/25 at 11:30 a.m. LPN-B stated when there are signs of infection such as change in drainage, abnormal vital signs, redness around the incision, or increase in pain the RN should have been notified, and she would contact the provider. When a resident has a daily dressing, the nurse would be expected to assess the incision for signs and symptoms of infection and document at least daily on what their assessment showed. R1's provider should have been contacted right away when a change was seen in her left hip incision to help identify infection, prevent sepsis and most likely could have made a difference. Anytime a provider was notified the nurse would be expected to		F0580				

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F0580 SS = D	Continued from page 8 document it so that it can be tracked and followed up on. During an interview on 9/24/25 at 1:23 p.m. medical doctor (MD) stated the nurse would be expected to rely on their judgement, when to notify the provider. When the nurse identified signs of drainage, increased redness, and fever, he would have expected to be contacted right away. He was always available to be contacted and would have wanted to know as soon as signs and symptoms of infection were identified. He would have expected the nurse to contact him on 9/1/25, he was traveling at that time and on vacation and the on-call provider would have been the one to contact. He did not recall being contacted on 9/2/25 but had a message on 9/3/25 regarding R1. He was unsure of what the message was about. During an interview on 9/24/25 at 1:50 p.m. registered nurse (RN)-B stated she was asked to assess R1's left hip incision on 9/4/25, it was noted to be red, swollen with pain and erythema. R1 informed her the incision throbbed and ached and her temperature was 100.0 degrees F. All those signs and symptoms were of infection, and she needed antibiotic therapy. She left a phone page to MD, and he usually responded even if he was on vacation. The nurse would be expected to document on her left hip incision/dressing daily to monitor for infection, catch it faster, less need for antibiotics, and decrease the likelihood of sepsis. During an interview on 9/24/25 at 2:45 p.m. hospital MD-B stated if R1 would have been brought to ER even a day or two earlier she may not have become septic. The sooner the sooner you can recognize signs and symptoms of infection, contact the provider, get them treatment the better the outcome. The abscess was quite big in her hip and required surgery, I&D. Cultures were completed and antibiotics started. Her sepsis could have been life threatening. During an interview on 9/24/25 at 4:00 p.m. LPN-C stated right after (unsure of date) R1 had her staples removed from her left hip incision on 8/26/25, the incision started oozing clear but pale-yellow scant amount of drainage from the top part. A provider should have been contacted when signs and symptoms of infection were present such as bleeding, uncontrollable pain/fever/signs, and symptoms to help prevent the resident's condition from getting any worse.		F0580				

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F0580 SS = D	Continued from page 9 During an interview on 9/25/25 at 1:00 p.m. RN-C stated R1's assessment should have included the skin/incision each time to monitor for infection and make sure the incision was healing well without adhesions. The nurse would be expected to notify a provider right away when signs/symptoms of infection are noted such as fever, redness around incision, change in drainage, pain, change in mental status. Purulent drainage meant there was pus and infection present on 9/1/25 and a provider should have been called and documented. During an interview on 9/25/25 at 1:39 p.m. RN-D stated there was a noted change in R1's left hip skin/incision on 9/1/25, charge nurse and the provider should have been notified. There was an event created on 9/3/25, provider contacted but only for her foot. RN-D verified there was no skin/incision assessments completed from 8/27/25 through 8/31/25 (4 days) and should have been. On 9/1/25, documentation identified a changed in her incision, a decline, signs of infection which would have been considered a significant change. The nurse would have been expected to contact the provider and documented so that we could have followed up on it. Recognizing signs and symptoms of infection early was important. During an interview on 9/25/25 at 3:43 p.m. DON verified from 8/27/25 through 8/31/25, there was no documentation of a skin assessment on R1's left hip incision and should have been completed at least once a shift to monitor for signs and symptoms of infection. The nurse would be expected to contact the provider right away when signs and symptoms of infection are seen such as increase in pain, drainage, purulent drainage, fever, and redness. The nurse can contact the provider by texting or calling depends on the provider and document. If it has been over two hours the nurse would be expected to follow up with the provider again so that continuity in care can be provided. The provider should have been contacted on 9/1/25 when purulent drainage, redness, and tenderness were noted on R1's left hip incision area. Identification of an infection early and starting an antibiotic would be important to avoid sepsis. Facility policy Preventing Skin Infections dated 9/2023, identified the purpose was to promote wound healing while preventing infection. Drainage identified as sanguineous: blood drainage; blood drainage in a		F0580				

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F0580 SS = D	Continued from page 10 chronic wound may represent a sign of increased microbial load in the wound, which indicates an assessment for signs of infection was needed. Localized signs of infection would be erythema, induration (hardening of tissue around the wound site can indicate inflammation/infection), increased drainage, change in character of tissue, foul odor, increased pain at wound site, delayed wound healing, general malaise, mental confusion, loss of appetite, leukocytosis, fever (often not present in elderly), hypothermia, blood sugar changes in diabetic. Document progress toward healing following facility protocol on when to request change of treatment. Facility policy Change in Condition dated 10/2/23, identified the provided care and services are based upon the current needs of the resident under the direction of the attending provider. When a significant change in the resident's physical, mental, or psychosocial status is identified by the licensed nurse, or when there is need to alter treatment significantly, the licensed nursing associate consults with the attending provider and notify the resident/resident representative. Assess significant change in the resident's condition noted through direct observation, interview, or report for [sic] other staff. Notify the attending provider of the change in condition and implement orders for treatment and appropriate monitoring as directed. If unable to contact the physician, contact the medical director as appropriate. Document symptoms, assessment, observations, resident/resident representative, and medical provider notification.		F0580				
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 ensure 1 of 3 residents (R1) received necessary medical attention following a change		F0684	During the complaint survey process it was noted that R1 did not receive necessary medical attention following a change in condition where the facility failed to comprehensively assess, monitor, and document skin changes. R1 returned from the hospital on 9/10/2025. R1's current condition is stable. R1's care plan has been reviewed and updated and skin conditions are monitored weekly and per physician orders. All residents have the ability to be affected by this deficient practice. A facility-wide audit was conducted to ensure a weekly skin audit has been conducted for all residents and any identifiable issues were properly notified to the physician. Facility policy on prevention and treatment of skin		10/27/2025	

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F0684 SS = G	Continued from page 11 in a left hip surgical incision. Additionally, the facility failed to comprehensively assess, monitor, and document skin changes. R1 sustained actual harm and required hospitalization, surgery, and insertion of a peripherally inserted central line catheter (PICC) for intravenous (IV) antibiotic treatment for sepsis. Findings include: R1's hospital discharge summary dated 8/1/25, identified mechanical ground level fall after losing her balance and sustained a left subtrochanteric femur fracture. She required surgery that included an surgical open reduction and internal fixation (ORIF) of the left hip and tramedullary nailing of left femur. Surgical incision noted to left hip with dressing. R1's progress notes from 8/25/25 through 9/10/25, identified: -8/25/25 at 2:57 p.m. Weekly Skin Check: R1 continued with stapes to surgical incision on the left hip/thigh. No new skin issues noted. -8/25/25 at 3:06 p.m. Skilled Nursing Documentation: Surgical wound left hip/thigh, no drainage, surrounding tissue intact and no pain. Nursing interventions: surgical wound care. -8/26/25 at 1:42 p.m. Skilled Nursing Documentation: Surgical wound left hip/thigh, no drainage, surrounding tissue intact and no pain. Nursing Interventions: surgical wound care. -8/26/25 at 8:33 p.m. Staples to left hip/thigh removed per order. R1 tolerated well. Cleansed area with saline and applied steri strips. -8/27/25, 8/28/25, 8/29/26, 8/30/25, Skilled Nursing Documentation completed. No documentation in progress notes on left hip/thigh incision (4 days). -9/1/25 at 8:43 a.m. Surgical wound left hip scant amount of purulent (thick and milky discharge from a wound and almost always indicates an infection, should not be ignored, and needs treatment as soon as possible) drainage. Surrounding tissue erythema (redness that occurs when extra blood rushes to an area and often indicates inflammation or infection). Pain was present with tenderness to upper aspect of incision. Nursing interventions: proper positioning and surgical wound care.		F0684	Continued from page 11 breakdown was reviewed on 10/16/2025. No changes were made to the policy. Associated staff were educated on the weekly skin assessments, documentation and assessment of skin related issues and the facility process for this on 10/17/2025. Skin assessments will be audited for all residents on a weekly basis to ensure each resident gets a skin assessment weekly per schedule x 4 weeks. 10 residents will be reviewed weekly x 8 weeks for completion of skin assessments weekly and as needed thereafter as determined by quality council for continued compliance. DON/DON designee are responsible for compliance.			

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F0684 SS = G	Continued from page 12 -9/1/25 at 8:43 a.m. Skin Assessment: Skin check done prior to shower. Surgical incision to left hip is red and warm to upper half of incision. R1 does report some tenderness to area. Scant purulent drainage noted to two areas of upper incision: bottom area measuring 1.3 centimeters (cm) along incision and top area measuring 3 cm along incision. Cleansed with wound wash and patted dry. Waterproof surgical post op bandage applied. -9/1/25 at 11:59 a.m. as needed (PRN) Tylenol given at 12:00 p.m. per her request for pain. -9/1/25 at 2:19 p.m. Surgical wound left hip scant amount of purulent drainage, surrounding tissue erythema, and no pain. Interventions to promote healing and prevent infection: proper positioning and surgical wound care. -9/2/25 at 2:19 p.m. surgical wound left hip scant amount of purulent drainage, surrounding tissue erythema, and no pain. Interventions used to promote healing and prevent infection: positioning and surgical wound care. -9/3/25 at 4:07 p.m. R1 had red and warm to touch right foot/toes. Charge nurse sent picture to primary provider medical doctor (MD) who ordered Bactrim double strength (DS) two times a day (BID) times 7 days. Orders updated. -9/3/25 at 11:18 p.m. Skilled Nursing documentation completed. Skin and/or left hip incision was not included in this entry. -9/4/25 at 6:24 p.m. Nurse was asked to check left hip as was noted to be red and swollen today with pain. Started on Bactrim yesterday. Area or [sic] erythema and edema marked earlier. There was a Meplix surgical in place with 430% [sic] serous drainage present to foam. The area marked has not spread and is 37 x 34 cm. There is a peau d [sic] orange skin texture. Skin is warm and erythematous. R1 reported it throbs and aches. Temperature 100.0 (F). Report sent to MD. Further vitals checked at within proximity to last check. No response from MD yet. Did report to oncoming nurse no response yet and encouraged to monitor vitals more frequently throughout the evening. Told R1 she may need an evaluation through the hospital and possible increase in antibiotics and she said no. When asked further she stated she did not wish to go to the hospital. She was informed a message was sent to the provider and that they would continue to monitor.		F0684				

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F0684 SS = G	Continued from page 13 Instructed to report feeling of chills or sweats. -9/4/25 at 7:11 p.m. MD responded thinking of a resident transfer to higher level of care. Awaiting orders for transfer to local ER vs another hospital. R1 agreed with transfer stated, "if she had to". Nurse on duty was aware of pending transfer. Hand off report had been given. -9/4/25 at 7:28 p.m. R1 was transferred to local hospital via son. Bed holds in place. -9/5/25 at 8:43 a.m. Discussed at interdisciplinary team (IDT): transferred to local hospital due to worsening of infection of left hip. -9/10/25 at 10:55 a.m. R1's planned arrival date back to facility 9/10/25 around 11:30 a.m. to 12:00 p.m. Admission diagnoses: sepsis due to post surgical abscess. Cares: peripherally inserted central catheter (PICC) (a long flexible catheter goes into your upper arm vein, through the vein in the arm and into a large vein located by the heart and allowed for long term access to infuse IV fluids, medications, and draw blood) line/antibiotic (Abx) for six weeks and wound vac/Prevena (not to be removed until batteries die) left hip. -9/10/25 at 12:35 p.m. R1 admitted from hospital in stable condition. -9/10/25 at 4:22 p.m. Skin assessment: left hip incision swollen and redness noted with wound vac in place. Left posterior calf open area 4 x 1 cm and 0.5 cm deep with clear drainage. Meplix dressing over Silvadene gauze ordered. R1's treatment administration record (TAR) August 2025, identified: -Change Mepilex dressing daily to left hip, start dated 8/19/25. Dressing change was signed off as being completed on 8/20/25, 8/22/25 through 8/26/25, 8/29/25, through 8/31/25. Dressing was signed off as not completed on 8/21/25 (not administered: due to condition), 8/27/25 (dressing changed at appointment) and 8/28/25 (did not want dressing on). -Complete weekly skin check observation and record vitals once a day on Monday. Documented on 8/4/25, not administered, no bath. Documented completed on 8/11/25, 8/18/25, and 8/25/25.			F0684			

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NAME OF PROVIDER OR SUPPLIER Benedictine Care Community				STREET ADDRESS, CITY, STATE, ZIP CODE 201 9TH STREET WEST , ADA, Minnesota, 56510			
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F0684 SS = G	Continued from page 14 R1's TAR September 2025, identified: -Change Mepilex dressing daily to left hip, start dated 8/19/25. Dressing changed was signed off as being completed on 9/1/25, 9/2/25, and 9/4/25. On 9/3/25, dressing change was documented as not completed. -Complete weekly skin check observation and record vitals once a day on Monday. Documented on 9/1/25 completed. -R1 was being treated for diagnosis abscess of left leg. Document every shift (3 times a day) in progress notes if these signs and symptoms are noted: temperature, pus present at wound skin or soft tissue site, new or increase in heat, redness, swelling, tenderness/pain, serous drainage at the affected site, changes in mental status and/or increase in ADL assistance. Start dated 9/12/25. Signed off not completed on 9/12/25 (1 time) (will administer when awake), 9/16/25 (1 time) (resident unavailable), and 9/24/25 (1 time) (did not get done in a.m.). R1's admission to hospital dated 9/5/25, identified admitted to hospital for post-surgical abscess and overlying abscess or previous left subtrochanteric femur fracture due to ground level fall status post ORIF with intramedullary nailing of left femur. Sepsis and increased left hip pain was due to the above. Orthopedics consulted, plan for surgery in a.m. Given her sepsis started on IV antibiotics Vancomycin and Rocephin. Today brought in by her son as over the last several days had noticed around her incision drainage and redness. Has noted a yellowish color to the drainage. Fever developed over the last 24 hours. She is also noted pain had increased in the left hip over the past few days to the point where she was unable to walk. It sounded like prior to this she was doing well. In the emergency department (ED) she had chills along with a fever of 100.0 degrees Fahrenheit (F), heart rate 114. Lab work completed shower elevated white blood cells (WBC) of 13.4 with left shift, stable hemoglobin, elevated C-reactive protein (CRP) (measures level of a protein in your blood that indicates inflammation) of 166 milligrams per liter (mg/L) (normal range less than 2.0 mg/L) and elevated erythrocyte sedimentation rate (ESR) (measures inflammation in the body) of 67 millimeters per hour (mm/hr.) (normal less than 30). CT scan showed abscess. Notable erythema over the proximal medial thigh extending over the lateral thigh midway down with increased erythema pronounced on the incision site. A		F0684				

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F0684 SS = G	Continued from page 15 bacterial culture with gram stain (laboratory test that helped diagnose harmful bacteria) of the left thigh tissue on 9/5/25, identified a rare staphylococcus aureus (a bacterial infection that can cause serious illness and become deadly if found in the blood stream, joints, bones, lungs, or heart, moderate white blood cells and treated with antibiotics), moderate white blood cells (WBC) (body produces more to fight an infection by attaching and destroying invading pathogens), and many red blood cells (RBC). A bacterial culture with gram stain dated 9/5/25, specimen taken from deep left thigh fluid identified rare staphylococcus aureus and corynebacterium aurimucosum (a nosocomial (occur in healthcare settings) pathogen infecting hard-to-heal peripheral wounds, such as skin wounds, soft tissue abscesses and osteomyelitis) and many WBC. R1’s care plan dated 9/10/25, identified at risk for skin alteration of skin due to limited/decreased mobility and pain. Staff were directed to observe skin integrity daily with cares, bathing, report any reddened, irritated, bruised or open areas and any new skin concerns taken to the nurse to address. The skin risk assessment with Braden scale/tissue tolerance completed per guidelines. She had a PICC to deliver fluids/medications due to a diagnosis of abscess of left leg and directed staff to administer medications/antibiotics as ordered. She required wound care treatment plan as follows: keep wound vac in place for 7 days or until battery dies and dressing changes to surgical site. R1’s 5-day Minimum Data Set (MDS) dated 9/16/25, identified she was admitted on 8/4/25, hospitalized, and readmitted on 9/10/25. Cognition was intact with no behaviors. Diagnoses included fracture of the hip, peripheral vascular disease (PVD) (narrowed blood vessels reducing blood flow to the limbs), chronic obstructive pulmonary disease (COPD), surgical site incision infection with cares, and cellulitis to right lower limb. She was at risk for pressure ulcers. She required substantial/maximal assistance with roll left to right in bed, sit to lying, and lying to sitting, dependent for toileting hygiene, lower body dressing, sit to stand, and all transfers. R1’s orders from 8/1/25 through 9/13/25 identified:		F0684				

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F0684 SS = G	Continued from page 16 -8/3/25, leave occlusive dressing intact for: comments-keep Prevena (purple) dressing in place until wound vac dies. Remove and throw away. Replace with Mepilex. Change every 7 days with occlusive dressing. If incision is draining, ok to change dressing sooner. Keep covered until staple removal at 2 weeks pos-op. Nursing communication: if she is doing well, ok to remove staples at 2 weeks post-op at skilled nursing facility (SNF) and cancel follow-up appointment. -8/3/25, ice to affected area: ice to lower extremity, cold packs as needed for swelling a pain. Alternate 20 minutes on and 20 minutes off. Assess skin every 2 hours. Do not apply directly to skin. -8/19/25, change Mepilex dressing daily to left hip. May shower, cover incision with waterproof dressing so it does not get wet. -8/26/25, ok to remove staples on 8/26/25 if no drainage. If concerns call orthopedics. -9/10/25, cefazolin (Ancef) (antibiotic) 2,000 milligrams (mg) in sodium chloride 0.9%/50 millimeters (ml) administer IV every 8 hours for post op infection. -9/10/25, left hip incision/surgical site, abdominal (ABD) pad, secure with tape. Special instructions: incision has significant amount of drainage. Change as needed. -9/12/25, complete the weekly skin check observation. -9/12/25, Document in progress notes if these signs and symptoms are noted: temperature, pus present at wound skin or soft tissue site. New or increase in heat, redness, swelling, tenderness/pain, serous drainage at affected site, and change in mental status. Every shift: days/evening/nights. -9/13/25, Skill Charting: Pain-site/level/intensity/pharmacological/non-pharmacol ogical interventions, medical doctor (MD) appointments, . . . special instructions: skilled charting should be therapy, IV antibiotic and skin. R1's Hospital Discharge Summary dated 9/8/25, identified two days prior to admission to hospital she was noted to have redness and drainage at incision site. She was admitted to the hospital for surgical cellulitis, orthopedic surgery and infectious disease physician was consulted. Her intraoperative culture showed Morganella Morganii (an unusual opportunistic		F0684				

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F0684 SS = G	Continued from page 17 pathogen belonging to the Enterobacteriaceae (microorganisms that can grow in absence of oxygen such as gram-negative) family, primary associated with post-operative wound and urinary tract infections and known for its resistance to multiple antibiotics and evolving virulence. This bacterium often results in a high mortality rate with some infections) and a few peptoniphilus species (gram-positive, anaerobic (requiring absence of free oxygen) causes infections). She had been treated with broad-spectrum IV antibiotics during hospitalization and recommended to complete 6 weeks course of antibiotic discharging on IV Ertapenem per infectious disease physician recommendation. She also received wound VAC during this hospitalization and orthopedic surgery recommended to keep in place for 7 to 14 days or until battery dies, then place Mepilex over incision. Interagency Handoff Report dated 9/10/25, identified R1 was admitted to the hospital on 9/4/25, hospital events: presented to emergency department (ED) with complaints of left hip skin changes and drainage from surgical incision. ORIF of left hip with intramedullary nail placement on 7/29/25. Computerized tomography scan (CT) (imaging test that uses x-rays and a computer to create detailed pictures of your organs, bones, and tissues), showed large fluid collection. Intravenous (IV) fluids and antibiotics administered, orthopedics consulted, planned for incision and drainage (I&D) (procedure to drain pus from an abscess and clean it out to promote healing) tomorrow. Blood cultures completed and PICC inserted. During an observation /interview on 9/19/25 at 10:08 a.m. R1 sat in her wheelchair in her room fully dressed. She stated she had fallen at home and fractured her hip, had surgery, and then admitted to the nursing home. Her incision was healing pretty good, stitches were taken out but had a hard time when the nurse attempted to remove the two top stiches. The NA saw my incision was getting red on my upper thigh and told then nurse. She had also informed the nurse it was red, increased pain and drainage after the stiches came out. She had to be sent into ER, started on antibiotics and surgery to open it up twice to see where the infection was located. During an observation on 9/19/25 at 12:01 p.m. RN-D was in bathroom with R1 on the toilet. A clean brief was applied and pulled up to her thighs. She was lifted off the toilet with the PAL machinal lift with her feet		F0684				

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F0684 SS = G	Continued from page 18 placed on the platform. There was a Mepilex dressing approximately 1 inch wide located over her left hip incision dry and intact with small amount of shadow drainage with no redness on the surrounding skin or signs of infection per RN-D. R1 was getting ready to leave facility for a wound clinic visit scheduled for this afternoon. Peri cares completed, pants pulled up and lowered into her wheelchair. During an interview on 9/19/25 at 2:15 p.m. licensed practical nurse (LPN)-A stated after the staples were removed on 8/26/25, from R1's left hip incision there were two spots at the top of the incision that had a scant to moderate amount of bleeding and small amount of redness. She had cleaned it with warm mild soap, water and applied Mepilex dressing over it to catch the blood daily. On 9/1/25, R1 was more tender with purulent drainage noted at the top of the left hip incision whereas she did not have pain prior. She may have talked to the director of nursing (DON) that day, but nothing was documented so unsure. Usually with an incision that looked like this one on 9/1/25, could have indicated infection, a registered nurse (RN) should have been informed, assess it, and notify provider. Pictures could have been taken, sent to provider, and antibiotics ordered. The nursing assistants informed her a couple of times two days in a row it looked red, unsure which days those were, and she did not document it. R1's incision should have been reported to the provider on 9/1/25 or at least by 9/2/25 and was not documented. During an interview on 9/19/25 at 2:51 p.m. NA-A stated R1 had a one-inch-wide dressing on her left hip incision and redness was seen around the incision /dressing two days before she was sent to the hospital. She had informed the nurse both days. During an interview on 9/24/25 at 11:30 a.m. LPN-B stated the skilled nursing charting/documentation was required to be completed daily and should have included the skin assessment as well. We want to make sure there is no infection going on in the surgical incision. When there are signs of infection such as change in drainage, abnormal vital signs, redness around the incision, or increase in pain the RN should have been notified, and she would contact the provider. When a resident has a daily dressing, the nurse would be expected to assess the incision for signs and symptoms of infection and document at least daily on what their assessment showed. R1's provider should have been		F0684				

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F0684 SS = G	Continued from page 19 contacted right away when a change was seen in her left hip incision to help identify infection and prevent sepsis and most likely could have made a difference. Anytime a provider was notified the nurse would be expected to document it so that it can be tracked and followed up on. During an interview on 9/24/25 at 1:23 p.m. medical doctor (MD) stated R1's dressing change was ordered to be completed daily, and he would expect the nurse to assess, change the dressing and document daily. Would be important to complete a daily assessment to prevent infection and change the plan of care if necessary to promote healing. The nurse would be expected to rely on their judgement as to when to notify the provider. When the nurse identified signs of drainage, increased redness, and fever, he would have expected to be contacted right away. He was always available to be contacted and would have wanted to know as soon as signs and symptoms of infection were identified. He would have expected the nurse to contact him on 9/1/25, he was traveling at that time and on vacation and the on-call provider would have been the one to contact. He did not recall being contacted on 9/2/25 but had a message on 9/3/25 regarding R1. He was unsure of what the message was about. During an interview on 9/24/25 at 1:50 p.m. RN-B stated a weekly thorough skin assessment would be expected to be completed by the nurse and then a daily skin assessment if a daily dressing change was ordered to catch any changes and determine if any signs/symptoms of infection are present. She was asked to assess R1's left hip incision on 9/4/25, it was noted to be red, swollen with pain and erythema. R1 informed her the incision throbbed and ached and her temperature was 100.0 degrees F. All those signs and symptoms were of infection, and she needed antibiotic therapy. She left a phone page to MD, and he usually responded even if he was on vacation, very good about that. The nurse would be expected to document on her left hip incision/dressing daily to monitor for infection, catch it faster, less need for antibiotics, and decrease the likelihood of sepsis. During an interview on 9/24/25 at 2:45 p.m. hospital MD-B stated if R1 would have been brought to ER even a day or two earlier she may not have become septic. The sooner the sooner you can recognize signs and symptoms of infection, contact the provider, get them treatment the better the outcome. The abscess was quite big in		F0684				

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F0684 SS = G	Continued from page 20 her hip and required surgery, I&D. Cultures were completed, and antibiotics were started. Her sepsis could have been life threatening. During an interview on 9/24/25 at 4:00 p.m. LPN-C stated right after (unsure of date) R1 had her staples removed from her left hip incision on 8/26/25, the incision started oozing clear but pale-yellow scant amount of drainage from the top part. She did not document the drainage or the skin assessments of the incision when she changed the dressing. Unsure why she did not change the dressing on 9/3/25, no documentation provided in the progress notes. A provider should have been contacted when signs and symptoms of infection were present such as bleeding, uncontrollable pain/fever/signs, and symptoms to help prevent the resident's condition from getting any worse. During an interview on 9/25/25 at 1:00 p.m. RN-C stated she had completed daily skilled nursing assessments but was unsure what to click on and what areas were required to be documented on. She clicked on areas she thought was appropriate for each resident documented on. R1's assessment should have included her skin/incision each time to monitor for infection and make sure the incision was healing well without adhesions. The NAs are informed to let the nurse know if there are changes in skin and are good about doing that. She was unsure why she documented on 8/21/25, left hip dressing change was not completed d/t condition. The surrounding skin should have been assessed at that time and any changes documented to catch signs/symptoms of infection and prevent complications. The nurse would be expected to notify a provider right away when signs/symptoms of infection are noted such as fever, redness around incision, change in drainage, pain, change in mental status. Purulent drainage meant there was puss and infection present on 9/1/25 and a provider should have been called and documented. During an interview on 9/25/25 at 1:39 p.m. RN-D stated on the electronic medication administration record (EMAR) skilled nursing assessment were scheduled for every shift, however nursing staff were only required to have completed it once a day according to the guidelines. The order was placed in there that way so that it would not get missed. R1's left hip incision should have been assessed and documented every shift especially with a daily dressing change so that signs and symptoms of infection could have been recognized		F0684				

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F0684 SS = G	Continued from page 21 early on and prevent sepsis from occurring. There was a noted change in R1's left hip skin/incision on 9/1/25, charge nurse and the provider should have been notified. There was an event created on 9/3/25, provider contacted but only for her foot. RN-D verified there was no skin/incision assessments completed from 8/27/25 through 8/31/25 (4 days) and should have been. On 9/1/25, documentation identified a changed in her incision, a decline, signs of infection which would have been considered a significant change. The nurse would have been expected to contact the provider and documented so that we could have followed up on it. Recognizing signs and symptoms of infection early was important. During an interview on 9/25/25 at 3:43 p.m. DON stated the skill nursing assessment charting should have been completed daily and included the skin/incisions. She verified from 8/27/25 through 8/31/25, there was no documentation of a skin assessment on R1's left hip incision and should have been completed at least once a shift to monitor for signs and symptoms of infection. The nurse would be expected to assess the incision, surrounding skin when the daily dressing was completed and document their findings. The nurse would be expected to contact the provider right away when signs and symptoms of infection are seen such as increase in pain, drainage, purulent drainage, fever, and redness. The nurse can contact the provider by texting or calling depends on the provider and document. If it had been over two hours the nurse would be expected to follow up with the provider again so that continuity in care can be provided. The provider should have been contacted on 9/1/25 when purulent drainage, redness, and tenderness were noted on R1's left hip incision area. Identification of an infection early and starting an antibiotic would be important to avoid sepsis. Facility document Infection Prevention and Control (dressing changes and wound care) undated identified read the care plan of seeing resident to know if/how the wound is be cleaned and what type of dressing if needed should be applied. After wound care and/or dressing change has been completed documentation was required. Facility policy Preventing Skin Infections dated 9/2023, identified the purpose was to promote wound healing while preventing infection. Skin injuries will be observed daily or as ordered. If dressing change is not indicated daily, there will still be a	F0684		

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F0684 SS = G	Continued from page 22 visualization of the surrounding skin condition. A comprehensive wound assessment will be completed on a weekly basis and include location of skin injury, length, width, and depth measurements recorded in centimeters. Direction of length of tunneling and undermining if present. Appearance of wound base. Type and percentage of tissue in wound such as eschar, slough, granulation, epithelial. Drainage amount and characteristics including color, consistency, and odor. Drainage identified as sanguinous: blood drainage; blood drainage in a chronic wound may represent a sign of increased microbial load in the wound, which indicates an assessment for signs of infection was needed. Localized signs of infection would be erythema, induration (hardening of tissue around the wound site can indicate inflammation/infection), increased drainage, change in character of tissue, foul odor, increased pain at wound site, delayed wound healing, general malaise, mental confusion, loss of appetite, leukocytosis, fever (often not present in elderly), hypothermia, blood sugar changes in diabetic. Document progress toward healing following facility protocol on when to request change of treatment. Facility policy Change in Condition dated 10/2/23, identified the provided care and services are based upon the current needs of the resident under the direction of the attending provider. When a significant change in the resident's physical, mental, or psychosocial status is identified by the licensed nurse, or when there is need to alter treatment significantly, the licensed nursing associate consults with the attending provider and notify the resident/resident representative. Assess significant change in the resident's condition noted through direct observation, interview, or report for [sic] other staff. Notify the attending provider of the change in condition and implement orders for treatment and appropriate monitoring as directed. If unable to contact the physician, contact the medical director as appropriate. Document symptoms, assessment, observations, resident/resident representative, and medical provider notification.		F0684				

Minnesota State Department of Health

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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 9/19/25, 9/24/25, and 9/25/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.		20000			10/17/2025	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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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 09/25/2025	
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 The following complaint was reviewed: H55024293C (2614476) with a licensing orders issued at 0265 and 0830. 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				
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development		20265	During the complaint survey process, it was noted that the facility failed to promptly notify a physician of a change in condition for R1. R1's physician was notified on 9/4/2025 along with the resident's representative on 9/4/2025 date. Resident's care plan was reviewed on 9/10/2025 and remains current. Physician was in to see resident on 9/11/2025 to complete recert. Progress notes have been reviewed from 9/10/2025 to current and no other untimely notifications were identified.		10/27/2025	

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20265	Continued from page 2 of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to promptly notify a physician of a change in condition for 1 of 3 residents (R1) reviewed when a left hip surgical incision showed signs of infection and required hospitalization. Findings include: R1's hospital discharge summary dated 8/1/25, identified mechanical ground level fall after losing her balance and sustained a left subtrochanteric femur fracture. She required surgery that included an ORIF and tramedullary nailing of left femur. Surgical incision noted to left hip with dressing. R1's progress notes from 8/26/25 through 9/10/25, identified: -8/26/25 at 1:42 p.m. Skilled Nursing Documentation: Surgical wound left hip/thigh, no drainage, surrounding tissue intact and no pain. Nursing Interventions:			20265	Continued from page 2 All residents have the ability to be affected by this deficient practice. A review of progress notes since the date of the complaint survey 9/25/25 to present were reviewed for all residents and no other incidents of untimely notification were identified for any other residents. A new facility policy on notification of changes was approved on 10/16/2025 and education was provided to all associated staff on the new policy and incidents to which could potentially prompt notification to a physician on 10/17/2025. Audits will be conducted through the review of progress notes 5x a week to review for any changes in condition and timely notification for all residents x 4 weeks. Then the audits will go down to 3 days a week for all residents x 8 weeks and as needed thereafter as determined by quality council for continued compliance. DON/DON designee are responsible for compliance.		

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20265	Continued from page 3 surgical wound care. -8/26/25 at 8:33 p.m. Staples to left hip/thigh removed per order. R1 tolerated well. Cleansed area with saline and applied steri strips. -8/27/25, 8/28/25, 8/29/26, 8/30/25, Skilled Nursing Documentation completed. No documentation in progress notes on left hip/thigh incision (4 days). -9/1/25 at 8:43 a.m. Surgical wound left hip scant amount of purulent (thick and milky discharge from a wound and almost always indicates an infection, should not be ignored, and needs treatment as soon as possible) drainage. Surrounding tissue erythema (redness that occurs when extra blood rushes to an area and often indicates inflammation or infection). Pain was present with tenderness to upper aspect of incision. Nursing interventions: proper positioning and surgical wound care. -9/1/25 at 8:43 a.m. Skin Assessment: Skin check done prior to shower. Surgical incision to left hip is read and warm to upper half of incision. R1 does report some tenderness to area. Scant purulent drainage noted to two areas of upper incision: bottom area measuring 1.3 centimeters (cm) along incision and top area measuring 3 cm along incision. Cleansed with wound wash and patted dry. Waterproof surgical post op bandage applied. -9/1/25 at 11:59 a.m. as needed (PRN) Tylenol given at 12:00 p.m. per her request for pain. -9/1/25 at 2:19 p.m. Surgical wound left hip scant amount of purulent drainage, surrounding tissue erythema, and no pain. Interventions to promote healing and prevent infection: proper positioning and surgical wound care. -9/2/25 at 2:19 p.m. surgical wound left hip scant amount of purulent drainage, surrounding tissue erythema, and no pain. Interventions used to promote healing and prevent infection: positioning and surgical wound care. -9/3/25 at 4:07 p.m. R1 had red and warm to touch right foot/toes. Charge nurse sent picture to primary provider medical doctor (MD) who ordered Bactrim double strength (DS) two times a day (BID) times 7 days. Orders updated. -9/3/25 at 11:18 p.m. Skilled Nursing documentation completed. Skin and/or left hip incision was not		20265				

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20265	Continued from page 4 included in this entry. -9/4/25 at 6:24 p.m. Nurse was asked to check left hip as was noted to be read and swollen today with pain. Started on Bactrim yesterday. Area or [sic] erythema and edema marked earlier. There was a Meplix surgical in place with 430% [sic] serous drainage present to foam. The area marked has not spread and is 37 x 34 cm. There is a peau d [sic] orange skin texture. Skin is warm and erythematous. R1 reported it throbs and aches. Temperature 100.0 Freiheit (F). Report sent to MD. Further vitals checked at within proximity to last check. No response from MD yet. Did report to oncoming nurse no response yet and encouraged to monitor vitals more frequently throughout the evening. Told R1 she may need an evaluation through the hospital and possible increase in antibiotics and she said no. When asked further she stated she did not wish to go to the hospital. She was informed a message was sent to the provider and that they would continue to monitor. Instructed to report feeling of chills or sweats. -9/4/25 at 7:11 p.m. MD responded thinking of a resident transfer to higher level of care. Awaiting orders for transfer to local ER vs another hospital. R1 agreed with transfer stated, "if she had to". Nurse on duty was aware of pending transfer. Hand off report had been given. -9/4/25 at 7:28 p.m. R1 was transferred to local hospital via son. Bed holds in place. -9/5/25 at 8:43 a.m. Discussed at interdisciplinary team (IDT): transferred to local hospital due to worsening of infection of left hip. -9/10/25 at 10:55 a.m. R1's planned arrival date back to facility 9/10/25 around 11:30 a.m. to 12:00 p.m. Admission diagnoses: sepsis due to post surgical abscess. Cares: peripherally inserted central catheter (PICC) (a long flexible catheter goes into your upper arm vein, through the vein in the arm and into a large vein located by the heart and allowed for long term access to infuse IV fluids, medications, and draw blood) line/antibiotic (Abx) for six weeks and wound vac/Prevena (not to be removed until batteries die) left hip. -9/10/25 at 12:35 p.m. R1 admitted from hospital in stable condition. -9/10/25 at 4:22 p.m. Skin assessment: left hip incision swollen and redness noted with wound vac in place. Left posterior calf open area 4 x 1 cm and 0.5		20265				

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20265	Continued from page 5 cm deep with clear drainage. Meplix dressing over Silvadene gauze ordered. R1’s admission to hospital dated 9/5/25, identified admitted to hospital for post-surgical abscess and overlying abscess or previous left subtrochanteric femur fracture due to ground level fall status post ORIF with intramedullary nailing of left femur. Sepsis and increased left hip pain was due to the above. Orthopedics consulted, plan for surgery in a.m. Given her sepsis started on IV antibiotics Vancomycin and Rocephin. Today brought in by her son as over the last several days had noticed around her incision drainage and redness. Has noted a yellowish color to the drainage. Fever developed over the last 24 hours. She is also noted pain had increased in the left hip over the past few days to the point where she was unable to walk. It sounded like prior to this she was doing well. In the emergency department (ED) she had chills along with a fever of 100.0 degrees Fahrenheit (F), heart rate 114. Lab work completed shower elevated white blood cells (WBC) of 13.4 with left shift, stable hemoglobin, elevated C-reactive protein (CRP) (measures level of a protein in your blood that indicates inflammation) of 166 milligrams per liter (mg/L) (normal range less than 2.0 mg/L) and elevated erythrocyte sedimentation rate (ESR) (measures inflammation in the body) of 67 millimeters per hour (mm/hr.) (normal less than 30). CT scan showed abscess. Notable erythema over the proximal medial thigh extending over the lateral thigh midway down with increased erythema pronounced on the incision site. A bacterial culture with gram stain (laboratory test that helped diagnose harmful bacteria) of the left thigh tissue on 9/5/25, identified a rare staphylococcus aureus (a bacterial infection that can cause serious illness and become deadly if found in the blood stream, joints, bones, lungs, or heart, moderate white blood cells and treated with antibiotics), moderate white blood cells (WBC) (body produces more to fight an infection by attaching and destroying invading pathogens), and many red blood cells (RBC). A bacterial culture with gram stain dated 9/5/25, specimen taken from deep left thigh fluid identified rare staphylococcus aureus and corynebacterium aurimucosum (a nosocomial (occur in healthcare settings) pathogen infecting hard-to-heal peripheral wounds, such as skin wounds, soft tissue abscesses and osteomyelitis) and many WBC. R1’s care plan dated 9/10/25, identified at risk for skin alteration of skin due to limited/decreased		20265				

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20265	Continued from page 6 mobility and pain. Staff were directed to observe skin integrity daily with cares, bathing, report any reddened, irritated, bruised or open areas and any new skin concerns taken to the nurse to address. R1's 5-day Minimum Data Set (MDS) dated 9/16/25, identified she was admitted on 8/4/25, hospitalized, and readmitted on 9/10/25. Cognition was intact with no behaviors. Diagnoses included fracture of the hip, peripheral vascular disease (PVD) (narrowed blood vessels reducing blood flow to the limbs), chronic obstructive pulmonary disease (COPD), surgical site incision infection, and cellulitis to right lower limb. R1's orders from 8/1/25 through 9/13/25 identified: -8/3/25, leave occlusive dressing intact for: comments-keep Prevena (purple) dressing in place until wound vac dies. Remove and throw away. Replace with Mepilex. Change every 7 days with occlusive dressing. If incision is draining, ok to change dressing sooner. Keep covered until staple removal at 2 weeks pos-op. Nursing communication: if she is doing well, ok to remove staples at 2 weeks post-op at skilled nursing facility (SNF) and cancel follow-up appointment. -8/3/25, ice to affected area: ice to lower extremity, cold packs as needed for swelling a pain. Alternate 20 minutes on and 20 minutes off. Assess skin every 2 hours. Do not apply directly to skin. -8/19/25, change Mepilex dressing daily to left hip. May shower, cover incision with waterproof dressing so it does not get wet. -8/26/25, ok to remove staples on 8/26/25 if no drainage. If concerns call orthopedics. -9/10/25, cefazolin (Ancef) (antibiotic) 2,000 milligrams (mg) in sodium chloride 0.9%/50 millimeters (ml) administer IV every 8 hours for post op infection. R1's Hospital Discharge Summary dated 9/8/25, identified two days prior to admission to hospital she was noted to have redness and drainage at incision site. She was admitted to the hospital for surgical cellulitis, orthopedic surgery and infectious disease physician was consulted. Her intraoperative culture showed Morganella Morganii (an unusual opportunistic pathogen belonging to the enterbacteriaceae (microorganisms that can grow in absence of oxygen such		20265				

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20265	Continued from page 7 as gram-negative) family, primary associated with post-operative wound and urinary tract infections and known for its resistance to multiple antibiotics and evolving virulence. This bacterium often results in a high mortality rate with some infections) and a few peptoniphilus species (gram-positive, anaerobic (requiring absence of free oxygen) causes infections). She had been treated with broad-spectrum IV antibiotics during hospitalization and recommended to complete 6 weeks course of antibiotic discharging on IV Ertapenem per infectious disease physician recommendation. She also received wound VAC during this hospitalization and orthopedic surgery recommended to keep in place for 7 to 14 days or until battery dies, then place Mepilex over incision. Interagency Handoff Report dated 9/10/25, identified R1 was admitted to the hospital on 9/4/25, hospital events: presented to emergency department (ED) with complaints of left hip skin changes and drainage from surgical incision. ORIF of left hip with intramedullary nail placement on 7/29/25. Computerized tomography scan (CT) (imaging test that uses x-rays and a computer to create detailed pictures of your organs, bones, and tissues), showed large fluid collection. Intravenous (IV) fluids and antibiotics administered, orthopedics consulted, planned for incision and drainage (I&D) (procedure to drain pus from an abscess and clean it out to promote healing) tomorrow. Blood cultures completed. PICC (a long flexible catheter goes into your upper arm vein, through the vein in the arm and into a large vein located by the heart and allowed for long term access to infuse IV fluids, medications, and draw blood). During an interview on 9/19/25 at 10:08 a.m. R1 stated her left hip incision was healing pretty good, stitches were taken out but had a hard time when the nurse attempted to remove the two top stiches. The NA saw my incision was getting red on my upper thigh and told then nurse. She had also informed the nurse it was red, increased pain and drainage after the stiches came out. She had to be sent into ER, started on antibiotics and surgery to open it up twice to see where the infection was located. During an interview on 9/19/25 at 2:15 p.m. licensed practical nurse (LPN)-A stated after the staples were removed on 8/26/25, from R1's left hip incision there were two spots at the top of the incision that had a scant to moderate amount of bleeding and small amount		20265				

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20265	Continued from page 8 of redness. She had cleaned it with warm mild soap, water and applied Mepilex dressing over it to catch the blood daily. On 9/1/25, R1 was more tender with purulent drainage noted at the top of the left hip incision whereas she did not have pain prior. She may have talked to the director of nursing (DON) that day, but nothing was documented so unsure. Usually with an incision that looked like this one on 9/1/25, could have indicated infection, a registered nurse (RN) should have been informed, assess it, and notified provider. Pictures could have been taken, sent to provider, and antibiotics ordered. The nursing assistants informed her a couple of times two days in a row it looked red, unsure which days those were, and she neglected to document it. R1's incision should have been reported to the provider on 9/1/25 or at least by 9/2/25 and was not documented. During an interview on 9/19/25 at 2:51 p.m. nursing assistant (NA)-A stated R1 had a one-inch-wide dressing on her left hip incision and redness was seen around the incision /dressing two days before she was sent to the hospital. She had informed the nurse both days. During an interview on 9/24/25 at 11:30 a.m. LPN-B stated when there are signs of infection such as change in drainage, abnormal vital signs, redness around the incision, or increase in pain the RN should have been notified, and she would contact the provider. When a resident has a daily dressing, the nurse would be expected to assess the incision for signs and symptoms of infection and document at least daily on what their assessment showed. R1's provider should have been contacted right away when a change was seen in her left hip incision to help identify infection, prevent sepsis and most likely could have made a difference. Anytime a provider was notified the nurse would be expected to document it so that it can be tracked and followed up on. During an interview on 9/24/25 at 1:23 p.m. medical doctor (MD) stated the nurse would be expected to rely on their judgement, when to notify the provider. When the nurse identified signs of drainage, increased redness, and fever, he would have expected to be contacted right away. He was always available to be contacted and would have wanted to know as soon as signs and symptoms of infection were identified. He would have expected the nurse to contact him on 9/1/25, he was traveling at that time and on vacation and the on-call provider would have been the one to contact. He		20265				

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20265	Continued from page 9 did not recall being contacted on 9/2/25 but had a message on 9/3/25 regarding R1. He was unsure of what the message was about. During an interview on 9/24/25 at 1:50 p.m. registered nurse (RN)-B stated she was asked to assess R1's left hip incision on 9/4/25, it was noted to be red, swollen with pain and erythema. R1 informed her the incision throbbed and ached and her temperature was 100.0 degrees F. All those signs and symptoms were of infection, and she needed antibiotic therapy. She left a phone page to MD, and he usually responded even if he was on vacation. The nurse would be expected to document on her left hip incision/dressing daily to monitor for infection, catch it faster, less need for antibiotics, and decrease the likelihood of sepsis. During an interview on 9/24/25 at 2:45 p.m. hospital MD-B stated if R1 would have been brought to ER even a day or two earlier she may not have become septic. The sooner the sooner you can recognize signs and symptoms of infection, contact the provider, get them treatment the better the outcome. The abscess was quite big in her hip and required surgery, I&D. Cultures were completed and antibiotics started. Her sepsis could have been life threatening. During an interview on 9/24/25 at 4:00 p.m. LPN-C stated right after (unsure of date) R1 had her staples removed from her left hip incision on 8/26/25, the incision started oozing clear but pale-yellow scant amount of drainage from the top part. A provider should have been contacted when signs and symptoms of infection were present such as bleeding, uncontrollable pain/fever/signs, and symptoms to help prevent the resident's condition from getting any worse. During an interview on 9/25/25 at 1:00 p.m. RN-C stated R1's assessment should have included the skin/incision each time to monitor for infection and make sure the incision was healing well without adhesions. The nurse would be expected to notify a provider right away when signs/symptoms of infection are noted such as fever, redness around incision, change in drainage, pain, change in mental status. Purulent drainage meant there was pus and infection present on 9/1/25 and a provider should have been called and documented. During an interview on 9/25/25 at 1:39 p.m. RN-D stated		20265				

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20265	Continued from page 10 there was a noted change in R1’s left hip skin/incision on 9/1/25, charge nurse and the provider should have been notified. There was an event created on 9/3/25, provider contacted but only for her foot. RN-D verified there was no skin/incision assessments completed from 8/27/25 through 8/31/25 (4 days) and should have been. On 9/1/25, documentation identified a changed in her incision, a decline, signs of infection which would have been considered a significant change. The nurse would have been expected to contact the provider and documented so that we could have followed up on it. Recognizing signs and symptoms of infection early was important. During an interview on 9/25/25 at 3:43 p.m. DON verified from 8/27/25 through 8/31/25, there was no documentation of a skin assessment on R1’s left hip incision and should have been completed at least once a shift to monitor for signs and symptoms of infection. The nurse would be expected to contact the provider right away when signs and symptoms of infection are seen such as increase in pain, drainage, purulent drainage, fever, and redness. The nurse can contact the provider by texting or calling depends on the provider and document. If it has been over two hours the nurse would be expected to follow up with the provider again so that continuity in care can be provided. The provider should have been contacted on 9/1/25 when purulent drainage, redness, and tenderness were noted on R1’s left hip incision area. Identification of an infection early and starting an antibiotic would be important to avoid sepsis. Facility policy Preventing Skin Infections dated 9/2023, identified the purpose was to promote wound healing while preventing infection. Drainage identified as sanguineous: blood drainage; blood drainage in a chronic wound may represent a sign of increased microbial load in the wound, which indicates an assessment for signs of infection was needed. Localized signs of infection would be erythema, induration (hardening of tissue around the wound site can indicate inflammation/infection), increased drainage, change in character of tissue, foul odor, increased pain at wound site, delayed wound healing, general malaise, mental confusion, loss of appetite, leukocytosis, fever (often not present in elderly), hypothermia, blood sugar changes in diabetic. Document progress toward healing following facility protocol on when to request change of treatment.		20265				

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20265	Continued from page 11 Facility policy Change in Condition dated 10/2/23, identified the provided care and services are based upon the current needs of the resident under the direction of the attending provider. When a significant change in the resident's physical, mental, or psychosocial status is identified by the licensed nurse, or when there is need to alter treatment significantly, the licensed nursing associate consults with the attending provider and notify the resident/resident representative. Assess significant change in the resident's condition noted through direct observation, interview, or report for [sic] other staff. Notify the attending provider of the change in condition and implement orders for treatment and appropriate monitoring as directed. If unable to contact the physician, contact the medical director as appropriate. Document symptoms, assessment, observations, resident/resident representative, and medical provider notification. SUGGESTED METHOD OF CORRECTION: The DON or designee could work with the medical director to update policies and procedures for when to notify the physician of changes in the resident and then could educate staff. The DON or designee could also perform audits of resident records to determine if the physician had been notified as appropriate. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20265				
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R1) received necessary medical attention following a change in a left hip surgical incision. Additionally, the facility failed to comprehensively assess, monitor, and document skin changes. R1 sustained actual harm and		20830	During the complaint survey process it was noted that R1 did not receive necessary medical attention following a change in condition where the facility failed to comprehensively assess, monitor, and document skin changes. R1 returned from the hospital on 9/10/2025. R1's current condition is stable. R1's care plan has been reviewed and updated and skin conditions are monitored weekly and per physician orders. All residents have the ability to be affected by this deficient practice. A facility-wide audit was conducted to ensure a weekly skin audit has been conducted for all residents and any identifiable issues were properly notified to the physician. Facility policy on prevention and treatment of skin breakdown was reviewed on 10/16/2025. No changes were made to the policy. Associated staff were educated on the weekly skin assessments, documentation and assessment of skin related issues and the facility		10/27/2025	

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20830	Continued from page 12 required hospitalization, surgery, and insertion of a peripherally inserted central line catheter (PICC) for intravenous (IV) antibiotic treatment for sepsis. Findings include: R1's hospital admission history and physical dated 7/29/25, Impression and Plan: R1 had a fall while going to the bathroom in her hallway around 1:00 p.m. She denied losing consciousness and started having sharp left hip pain, could not move, laid on the floor for an hour before help could arrive. She was brought to emergency room (ER) and found to have a left femur fracture. Potassium was noted to be low at 2.8. She was admitted to the hospital and had surgical open reduction and internal fixation (ORIF) of the left hip. She hit head during the fall and sustained a small left parietal scalp hematoma (bleed) 3.2 centimeters (cm). R1's hospital discharge summary dated 8/1/25, identified mechanical ground level fall after losing her balance and sustained a left subtrochanteric femur fracture. She required surgery that included an ORIF and tramedullary nailing of left femur. Surgical incision noted to left hip with dressing. R1's progress notes from 8/25/25 through 9/10/25, identified: -8/25/25 at 2:57 p.m. Weekly Skin Check: R1 continued with stapes to surgical incision on the left hip/thigh. No new skin issues noted. -8/25/25 at 3:06 p.m. Skilled Nursing Documentation: Surgical wound left hip/thigh, no drainage, surrounding tissue intact and no pain. Nursing interventions: surgical wound care. -8/26/25 at 1:42 p.m. Skilled Nursing Documentation: Surgical wound left hip/thigh, no drainage, surrounding tissue intact and no pain. Nursing Interventions: surgical wound care. -8/26/25 at 8:33 p.m. Staples to left hip/thigh removed per order. R1 tolerated well. Cleansed area with saline and applied steri strips. -8/27/25, 8/28/25, 8/29/26, 8/30/25, Skilled Nursing Documentation completed. No documentation in progress notes on left hip/thigh incision (4 days).		20830	Continued from page 12 process for this on 10/17/2025. Skin assessments will be audited for all residents on a weekly basis to ensure each resident gets a skin assessment weekly per schedule x 4 weeks. 10 residents will be reviewed weekly x 8 weeks for completion of skin assessments weekly and as needed thereafter as determined by quality council for continued compliance. DON/DON designee are responsible for compliance.			

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20830	Continued from page 13 -9/1/25 at 8:43 a.m. Surgical wound left hip scant amount of purulent (thick and milky discharge from a wound and almost always indicates an infection, should not be ignored, and needs treatment as soon as possible) drainage. Surrounding tissue erythema (redness that occurs when extra blood rushes to an area and often indicates inflammation or infection). Pain was present with tenderness to upper aspect of incision. Nursing interventions: proper positioning and surgical wound care. -9/1/25 at 8:43 a.m. Skin Assessment: Skin check done prior to shower. Surgical incision to left hip is red and warm to upper half of incision. R1 does report some tenderness to area. Scant purulent drainage noted to two areas of upper incision: bottom area measuring 1.3 centimeters (cm) along incision and top area measuring 3 cm along incision. Cleansed with wound wash and patted dry. Waterproof surgical post op bandage applied. -9/1/25 at 11:59 a.m. as needed (PRN) Tylenol given at 12:00 p.m. per her request for pain. -9/1/25 at 2:19 p.m. Surgical wound left hip scant amount of purulent drainage, surrounding tissue erythema, and no pain. Interventions to promote healing and prevent infection: proper positioning and surgical wound care. -9/2/25 at 2:19 p.m. surgical wound left hip scant amount of purulent drainage, surrounding tissue erythema, and no pain. Interventions used to promote healing and prevent infection: positioning and surgical wound care. -9/3/25 at 4:07 p.m. R1 had red and warm to touch right foot/toes. Charge nurse sent picture to primary provider medical doctor (MD) who ordered Bactrim double strength (DS) two times a day (BID) times 7 days. Orders updated. -9/3/25 at 11:18 p.m. Skilled Nursing documentation completed. Skin and/or left hip incision was not included in this entry. -9/4/25 at 6:24 p.m. Nurse was asked to check left hip as was noted to be red and swollen today with pain. Started on Bactrim yesterday. Area or [sic] erythema and edema marked earlier. There was a Meplix surgical in place with 430% [sic] serous drainage present to foam. The area marked has not spread and is 37 x 34 cm. There is a peau d [sic] orange skin texture. Skin is warm and erythematous. R1 reported it throbs and aches.		20830				

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20830	Continued from page 14 Temperature 100.0 (F). Report sent to MD. Further vitals checked at within proximity to last check. No response from MD yet. Did report to oncoming nurse no response yet and encouraged to monitor vitals more frequently throughout the evening. Told R1 she may need an evaluation through the hospital and possible increase in antibiotics and she said no. When asked further she stated she did not wish to go to the hospital. She was informed a message was sent to the provider and that they would continue to monitor. Instructed to report feeling of chills or sweats. -9/4/25 at 7:11 p.m. MD responded thinking of a resident transfer to higher level of care. Awaiting orders for transfer to local ER vs another hospital. R1 agreed with transfer stated, "if she had to". Nurse on duty was aware of pending transfer. Hand off report had been given. -9/4/25 at 7:28 p.m. R1 was transferred to local hospital via son. Bed holds in place. -9/5/25 at 8:43 a.m. Discussed at interdisciplinary team (IDT): transferred to local hospital due to worsening of infection of left hip. -9/10/25 at 10:55 a.m. R1's planned arrival date back to facility 9/10/25 around 11:30 a.m. to 12:00 p.m. Admission diagnoses: sepsis due to post surgical abscess. Cares: peripherally inserted central catheter (PICC) (a long flexible catheter goes into your upper arm vein, through the vein in the arm and into a large vein located by the heart and allowed for long term access to infuse IV fluids, medications, and draw blood) line/antibiotic (Abx) for six weeks and wound vac/Prevena (not to be removed until batteries die) left hip. -9/10/25 at 12:35 p.m. R1 admitted from hospital in stable condition. -9/10/25 at 4:22 p.m. Skin assessment: left hip incision swollen and redness noted with wound vac in place. Left posterior calf open area 4 x 1 cm and 0.5 cm deep with clear drainage. Meplix dressing over Silvadene gauze ordered. R1's treatment administration record (TAR) August 2025, identified: -Change Mepilex dressing daily to left hip, start dated 8/19/25. Dressing change was signed off as being completed on 8/20/25, 8/22/25 through 8/26/25, 8/29/25, through 8/31/25. Dressing was signed off as not		20830				

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20830	Continued from page 15 completed on 8/21/25 (not administered: due to condition), 8/27/25 (dressing changed at appointment) and 8/28/25 (did not want dressing on). -Complete weekly skin check observation and record vitals once a day on Monday. Documented on 8/4/25, not administered, no bath. Documented completed on 8/11/25, 8/18/25, and 8/25/25. R1's TAR September 2025, identified: -Change Mepilex dressing daily to left hip, start dated 8/19/25. Dressing changed was signed off as being completed on 9/1/25, 9/2/25, and 9/4/25. On 9/3/25, dressing change was documented as not completed. -Complete weekly skin check observation and record vitals once a day on Monday. Documented on 9/1/25 completed. -R1 was being treated for diagnosis abscess of left leg. Document every shift (3 times a day) in progress notes if these signs and symptoms are noted: temperature, pus present at wound skin or soft tissue site, new or increase in heat, redness, swelling, tenderness/pain, serous drainage at the affected site, changes in mental status and/or increase in ADL assistance. Start dated 9/12/25. Signed off not completed on 9/12/25 (1 time) (will administer when awake), 9/16/25 (1 time) (resident unavailable), and 9/24/25 (1 time) (did not get done in a.m.). R1's admission to hospital dated 9/5/25, identified admitted to hospital for post-surgical abscess and overlying abscess or previous left subtrochanteric femur fracture due to ground level fall status post ORIF with intramedullary nailing of left femur. Sepsis and increased left hip pain was due to the above. Orthopedics consulted, plan for surgery in a.m. Given her sepsis started on IV antibiotics Vancomycin and Rocephin. Today brought in by her son as over the last several days had noticed around her incision drainage and redness. Has noted a yellowish color to the drainage. Fever developed over the last 24 hours. She is also noted pain had increased in the left hip over the past few days to the point where she was unable to walk. It sounded like prior to this she was doing well. In the emergency department (ED) she had chills along with a fever of 100.0 degrees Fahrenheit (F), heart rate 114. Lab work completed shower elevated white blood cells (WBC) of 13.4 with left shift, stable hemoglobin, elevated C-reactive protein (CRP) (measures		20830				

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20830	Continued from page 16 level of a protein in your blood that indicates inflammation) of 166 milligrams per liter (mg/L) (normal range less than 2.0 mg/L) and elevated erythrocyte sedimentation rate (ESR) (measures inflammation in the body) of 67 millimeters per hour (mm/hr.) (normal less than 30). CT scan showed abscess. Notable erythema over the proximal medial thigh extending over the lateral thigh midway down with increased erythema pronounced on the incision site. A bacterial culture with gram stain (laboratory test that helped diagnose harmful bacteria) of the left thigh tissue on 9/5/25, identified a rare staphylococcus aureus (a bacterial infection that can cause serious illness and become deadly if found in the blood stream, joints, bones, lungs, or heart, moderate white blood cells and treated with antibiotics), moderate white blood cells (WBC) (body produces more to fight an infection by attaching and destroying invading pathogens), and many red blood cells (RBC). A bacterial culture with gram stain dated 9/5/25, specimen taken from deep left thigh fluid identified rare staphylococcus aureus and corynebacterium aurimucosum (a nosocomial (occur in healthcare settings) pathogen infecting hard-to-heal peripheral wounds, such as skin wounds, soft tissue abscesses and osteomyelitis) and many WBC. R1's care plan dated 9/10/25, identified at risk for skin alteration of skin due to limited/decreased mobility and pain. Staff were directed to observe skin integrity daily with cares, bathing, report any reddened, irritated, bruised or open areas and any new skin concerns taken to the nurse to address. The skin risk assessment with Braden scale/tissue tolerance completed per guidelines. She had a PICC to deliver fluids/medications due to a diagnosis of abscess of left leg and directed staff to administer medications/antibiotics as ordered. She required wound care treatment plan as follows: keep wound vac in place for 7 days or until battery dies and dressing changes to surgical site. R1's 5-day Minimum Data Set (MDS) dated 9/16/25, identified she was admitted on 8/4/25, hospitalized, and readmitted on 9/10/25. Cognition was intact with no behaviors. Diagnoses included fracture of the hip, peripheral vascular disease (PVD) (narrowed blood vessels reducing blood flow to the limbs), chronic obstructive pulmonary disease (COPD), surgical site incision infection with cares, and cellulitis to right		20830				

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20830	Continued from page 17 lower limb. She was at risk for pressure ulcers. She required substantial/maximal assistance with roll left to right in bed, sit to lying, and lying to sitting, dependent for toileting hygiene, lower body dressing, sit to stand, and all transfers. R1's orders from 8/1/25 through 9/13/25 identified: -8/3/25, leave occlusive dressing intact for: comments-keep Prevena (purple) dressing in place until wound vac dies. Remove and throw away. Replace with Mepilex. Change every 7 days with occlusive dressing. If incision is draining, ok to change dressing sooner. Keep covered until staple removal at 2 weeks pos-op. Nursing communication: if she is doing well, ok to remove staples at 2 weeks post-op at skilled nursing facility (SNF) and cancel follow-up appointment. -8/3/25, ice to affected area: ice to lower extremity, cold packs as needed for swelling a pain. Alternate 20 minutes on and 20 minutes off. Assess skin every 2 hours. Do not apply directly to skin. -8/19/25, change Mepilex dressing daily to left hip. May shower, cover incision with waterproof dressing so it does not get wet. -8/26/25, ok to remove staples on 8/26/25 if no drainage. If concerns call orthopedics. -9/10/25, cefazolin (Ancef) (antibiotic) 2,000 milligrams (mg) in sodium chloride 0.9%/50 millimeters (ml) administer IV every 8 hours for post op infection. -9/10/25, left hip incision/surgical site, abdominal (ABD) pad, secure with tape. Special instructions: incision has significant amount of drainage. Change as needed. -9/12/25, complete the weekly skin check observation. -9/12/25, Document in progress notes if these signs and symptoms are noted: temperature, pus present at wound skin or soft tissue site. New or increase in heat, redness, swelling, tenderness/pain, serous drainage at affected site, and change in mental status. Every shift: days/evening/nights. -9/13/25, Skill Charting: Pain-site/level/intensity/pharmacological/non-pharmacol ogical interventions, medical doctor (MD) appointments, . . . special instructions: skilled charting should be therapy, IV antibiotic and skin.		20830				

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20830	Continued from page 18 R1's Hospital Discharge Summary dated 9/8/25, identified two days prior to admission to hospital she was noted to have redness and drainage at incision site. She was admitted to the hospital for surgical cellulitis, orthopedic surgery and infectious disease physician was consulted. Her intraoperative culture showed Morganella Morganii (an unusual opportunistic pathogen belonging to the Enterobacteriaceae (microorganisms that can grow in absence of oxygen such as gram-negative) family, primary associated with post-operative wound and urinary tract infections and known for its resistance to multiple antibiotics and evolving virulence. This bacterium often results in a high mortality rate with some infections) and a few peptoniphilus species (gram-positive, anaerobic (requiring absence of free oxygen) causes infections). She had been treated with broad-spectrum IV antibiotics during hospitalization and recommended to complete 6 weeks course of antibiotic discharging on IV Ertapenem per infectious disease physician recommendation. She also received wound VAC during this hospitalization and orthopedic surgery recommended to keep in place for 7 to 14 days or until battery dies, then place Mepilex over incision. Interagency Handoff Report dated 9/10/25, identified R1 was admitted to the hospital on 9/4/25, hospital events: presented to emergency department (ED) with complaints of left hip skin changes and drainage from surgical incision. ORIF of left hip with intramedullary nail placement on 7/29/25. Computerized tomography scan (CT) (imaging test that uses x-rays and a computer to create detailed pictures of your organs, bones, and tissues), showed large fluid collection. Intravenous (IV) fluids and antibiotics administered, orthopedics consulted, planned for incision and drainage (I&D) (procedure to drain pus from an abscess and clean it out to promote healing) tomorrow. Blood cultures completed and PICC inserted. During an observation /interview on 9/19/25 at 10:08 a.m. R1 sat in her wheelchair in her room fully dressed. She stated she had fallen at home and fractured her hip, had surgery, and then admitted to the nursing home. Her incision was healing pretty good, stitches were taken out but had a hard time when the nurse attempted to remove the two top stiches. The NA saw my incision was getting red on my upper thigh and told then nurse. She had also informed the nurse it was red, increased pain and drainage after the stiches came		20830				

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20830	Continued from page 19 out. She had to be sent into ER, started on antibiotics and surgery to open it up twice to see where the infection was located. During an observation on 9/19/25 at 12:01 p.m. RN-D was in bathroom with R1 on the toilet. A clean brief was applied and pulled up to her thighs. She was lifted off the toilet with the PAL machinal lift with her feet placed on the platform. There was a Mepilex dressing approximately 1 inch wide located over her left hip incision dry and intact with small amount of shadow drainage with no redness on the surrounding skin or signs of infection per RN-D. R1 was getting ready to leave facility for a wound clinic visit scheduled for this afternoon. Peri cares completed, pants pulled up and lowered into her wheelchair. During an interview on 9/19/25 at 2:15 p.m. licensed practical nurse (LPN)-A stated after the staples were removed on 8/26/25, from R1's left hip incision there were two spots at the top of the incision that had a scant to moderate amount of bleeding and small amount of redness. She had cleaned it with warm mild soap, water and applied Mepilex dressing over it to catch the blood daily. On 9/1/25, R1 was more tender with purulent drainage noted at the top of the left hip incision whereas she did not have pain prior. She may have talked to the director of nursing (DON) that day, but nothing was documented so unsure. Usually with an incision that looked like this one on 9/1/25, could have indicated infection, a registered nurse (RN) should have been informed, assess it, and notify provider. Pictures could have been taken, sent to provider, and antibiotics ordered. The nursing assistants informed her a couple of times two days in a row it looked red, unsure which days those were, and she did not document it. R1's incision should have been reported to the provider on 9/1/25 or at least by 9/2/25 and was not documented. During an interview on 9/19/25 at 2:51 p.m. NA-A stated R1 had a one-inch-wide dressing on her left hip incision and redness was seen around the incision /dressing two days before she was sent to the hospital. She had informed the nurse both days. During an interview on 9/24/25 at 11:30 a.m. LPN-B stated the skilled nursing charting/documentation was required to be completed daily and should have included the skin assessment as well. We want to make sure there		20830				

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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	
20830	Continued from page 20 is no infection going on in the surgical incision. When there are signs of infection such as change in drainage, abnormal vital signs, redness around the incision, or increase in pain the RN should have been notified, and she would contact the provider. When a resident has a daily dressing, the nurse would be expected to assess the incision for signs and symptoms of infection and document at least daily on what their assessment showed. R1's provider should have been contacted right away when a change was seen in her left hip incision to help identify infection and prevent sepsis and most likely could have made a difference. Anytime a provider was notified the nurse would be expected to document it so that it can be tracked and followed up on. During an interview on 9/24/25 at 1:23 p.m. medical doctor (MD) stated R1's dressing change was ordered to be completed daily, and he would expect the nurse to assess, change the dressing and document daily. Would be important to complete a daily assessment to prevent infection and change the plan of care if necessary to promote healing. The nurse would be expected to rely on their judgement as to when to notify the provider. When the nurse identified signs of drainage, increased redness, and fever, he would have expected to be contacted right away. He was always available to be contacted and would have wanted to know as soon as signs and symptoms of infection were identified. He would have expected the nurse to contact him on 9/1/25, he was traveling at that time and on vacation and the on-call provider would have been the one to contact. He did not recall being contacted on 9/2/25 but had a message on 9/3/25 regarding R1. He was unsure of what the message was about. During an interview on 9/24/25 at 1:50 p.m. RN-B stated a weekly thorough skin assessment would be expected to be completed by the nurse and then a daily skin assessment if a daily dressing change was ordered to catch any changes and determine if any signs/symptoms of infection are present. She was asked to assess R1's left hip incision on 9/4/25, it was noted to be red, swollen with pain and erythema. R1 informed her the incision throbbed and ached and her temperature was 100.0 degrees F. All those signs and symptoms were of infection, and she needed antibiotic therapy. She left a phone page to MD, and he usually responded even if he was on vacation, very good about that. The nurse would be expected to document on her left hip incision/dressing daily to monitor for infection, catch it faster, less need for antibiotics, and decrease the		20830				

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20830	Continued from page 21 likelihood of sepsis. During an interview on 9/24/25 at 2:45 p.m. hospital MD-B stated if R1 would have been brought to ER even a day or two earlier she may not have become septic. The sooner the sooner you can recognize signs and symptoms of infection, contact the provider, get them treatment the better the outcome. The abscess was quite big in her hip and required surgery, I&D. Cultures were completed, and antibiotics were started. Her sepsis could have been life threatening. During an interview on 9/24/25 at 4:00 p.m. LPN-C stated right after (unsure of date) R1 had her staples removed from her left hip incision on 8/26/25, the incision started oozing clear but pale-yellow scant amount of drainage from the top part. She did not document the drainage or the skin assessments of the incision when she changed the dressing. Unsure why she did not change the dressing on 9/3/25, no documentation provided in the progress notes. A provider should have been contacted when signs and symptoms of infection were present such as bleeding, uncontrollable pain/fever/signs, and symptoms to help prevent the resident's condition from getting any worse. During an interview on 9/25/25 at 1:00 p.m. RN-C stated she had completed daily skilled nursing assessments but was unsure what to click on and what areas were required to be documented on. She clicked on areas she thought was appropriate for each resident documented on. R1's assessment should have included her skin/incision each time to monitor for infection and make sure the incision was healing well without adhesions. The NAs are informed to let the nurse know if there are changes in skin and are good about doing that. She was unsure why she documented on 8/21/25, left hip dressing change was not completed d/t condition. The surrounding skin should have been assessed at that time and any changes documented to catch signs/symptoms of infection and prevent complications. The nurse would be expected to notify a provider right away when signs/symptoms of infection are noted such as fever, redness around incision, change in drainage, pain, change in mental status. Purulent drainage meant there was puss and infection present on 9/1/25 and a provider should have been called and documented. During an interview on 9/25/25 at 1:39 p.m. RN-D stated		20830				

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20830	Continued from page 22 on the electronic medication administration record (EMAR) skilled nursing assessment were scheduled for every shift, however nursing staff were only required to have completed it once a day according to the guidelines. The order was placed in there that way so that it would not get missed. R1's left hip incision should have been assessed and documented every shift especially with a daily dressing change so that signs and symptoms of infection could have been recognized early on and prevent sepsis from occurring. There was a noted change in R1's left hip skin/incision on 9/1/25, charge nurse and the provider should have been notified. There was an event created on 9/3/25, provider contacted but only for her foot. RN-D verified there was no skin/incision assessments completed from 8/27/25 through 8/31/25 (4 days) and should have been. On 9/1/25, documentation identified a changed in her incision, a decline, signs of infection which would have been considered a significant change. The nurse would have been expected to contact the provider and documented so that we could have followed up on it. Recognizing signs and symptoms of infection early was important. During an interview on 9/25/25 at 3:43 p.m. DON stated the skill nursing assessment charting should have been completed daily and included the skin/incisions. She verified from 8/27/25 through 8/31/25, there was no documentation of a skin assessment on R1's left hip incision and should have been completed at least once a shift to monitor for signs and symptoms of infection. The nurse would be expected to assess the incision, surrounding skin when the daily dressing was completed and document their findings. The nurse would be expected to contact the provider right away when signs and symptoms of infection are seen such as increase in pain, drainage, purulent drainage, fever, and redness. The nurse can contact the provider by texting or calling depends on the provider and document. If it had been over two hours the nurse would be expected to follow up with the provider again so that continuity in care can be provided. The provider should have been contacted on 9/1/25 when purulent drainage, redness, and tenderness were noted on R1's left hip incision area. Identification of an infection early and starting an antibiotic would be important to avoid sepsis. Facility document Infection Prevention and Control (dressing changes and wound care) undated identified read the care plan of seeing resident to know if/how the wound is be cleaned and what type of dressing if needed should be applied. After wound care and/or		20830				

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20830	Continued from page 23 dressing change has been completed documentation was required. Facility policy Preventing Skin Infections dated 9/2023, identified the purpose was to promote wound healing while preventing infection. Skin injuries will be observed daily or as ordered. If dressing change is not indicated daily, there will still be a visualization of the surrounding skin condition. A comprehensive wound assessment will be completed on a weekly basis and include location of skin injury, length, width, and depth measurements recorded in centimeters. Direction of length of tunneling and undermining if present. Appearance of wound base. Type and percentage of tissue in wound such as eschar, slough, granulation, epithelial. Drainage amount and characteristics including color, consistency, and odor. Drainage identified as sanguinous: blood drainage; blood drainage in a chronic wound may represent a sign of increased microbial load in the wound, which indicates an assessment for signs of infection was needed. Localized signs of infection would be erythema, induration (hardening of tissue around the wound site can indicate inflammation/infection), increased drainage, change in character of tissue, foul odor, increased pain at wound site, delayed wound healing, general malaise, mental confusion, loss of appetite, leukocytosis, fever (often not present in elderly), hypothermia, blood sugar changes in diabetic. Document progress toward healing following facility protocol on when to request change of treatment. Facility policy Change in Condition dated 10/2/23, identified the provided care and services are based upon the current needs of the resident under the direction of the attending provider. When a significant change in the resident's physical, mental, or psychosocial status is identified by the licensed nurse, or when there is need to alter treatment significantly, the licensed nursing associate consults with the attending provider and notify the resident/resident representative. Assess significant change in the resident's condition noted through direct observation, interview, or report for [sic] other staff. Notify the attending provider of the change in condition and implement orders for treatment and appropriate monitoring as directed. If unable to contact the physician, contact the medical director as appropriate. Document symptoms, assessment, observations, resident/resident representative, and medical provider notification.		20830				

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20830	Continued from page 24 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for signs and symptoms of infection, assessment, monitoring, and documentation. Nursing staff could be educated as necessary to the importance of assessing/monitoring skin for signs and symptoms of infection and documentation. The DON or designee could audit any/all residents with skin concerns that have interventions in place. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20830				