DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 21, 2026

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

RE: CCN: 245502
Cycle Start Date: March 5, 2026

Dear Administrator:

On March 24, 2026, we notified you a remedy was imposed. On April 10, 2026, the Minnesota Departments of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 3, 2026.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective April 8, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 24, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 5, 2026. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Care Community	**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 1/22/26 through 1/28/26, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaints were reviewed. H55027340C (2788982) H55027600C (2792265) with deficiencies cited at F580, F684. The survey resulted in an Immediate Jeopardy (IJ) at F684 when the facility failed to identify, assess and act on a change of condition for R1 who had a fever, displayed hallucinations, pain and was demonstrating other signs of illness for multiple days, over multiple shifts. The IJ began on 2/21/26, and the immediacy was removed on 3/5/26. The above findings constituted substandard quality of care, and an extended survey was conducted on 3/5/26. As a result of the extended survey, deficiencies were issued at F943 and F882. 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		03/24/2026
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.	F0580	During the complaint survey process, it was noted that the facility failed to ensure physician notification of a change of condition for 1 of 3 residents (R1) reviewed who subsequently admitted to the hospital for septic shock.	04/03/2026

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

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

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F0580 SS = D	Continued from page 1 (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 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	F0580	Continued from page 1 R1 was transferred to the hospital on 2/24/26 for evaluation and treatment. The facility conducted an interdisciplinary review of R1's change in condition, hospitalization, and outcome. Education was immediately provided to all licensed nursing staff on requirements for physician notification related to changes in condition, including abnormal vital signs, behavioral changes, and signs/symptoms of infection. All residents have the ability to be affected by this deficient practice. An audit of all current residents was completed by the Director of Nursing (DON) or designee on 3/6/26 to identify any residents with recent changes in condition (past 7 days), including abnormal vital signs, infection symptoms, or behavioral changes. Any identified concerns were immediately assessed and providers notified as indicated. No additional concerns were identified. The facility reviewed and reinforced the Change in Condition, resident examination and evaluation policy to clearly define specific triggers for physician notification. The facility implemented a structured SBAR communication tool for all provider notifications. Education will be provided to all nurses on or by 3/31/2026 on the change in condition, resident examination and evaluation policy along with implementation of the SBAR communication tool. An audit will be conducted for documentation of change in condition, timeliness of physician notification, and documentation of interventions. The audit will include all residents daily for 4 weeks, then all residents daily, Monday-Friday for 8 additional weeks and as needed thereafter determined by quality council for continued compliance. DON/DON Designee is responsible for compliance.	

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F0580 SS = D	Continued from page 2 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 ensure physician notification of a change of condition for 1 of 3 residents (R1) reviewed who subsequently admitted to the hospital for septic shock. Findings include: R1's Annual Minimum Data Set dated 12/26/25, identified intact cognition and indicated she did not display hallucinations, delusions or behaviors. R1's care plan identified a self-care deficit and a potential for infection related to urinary incontinence. The care plan directed staff to update the provider as needed. The care plan indicated R1 was alert and oriented and independent in making decisions. R1's Vitals Report identified the following: 2/21/26 -10:32 a.m. temperature (Temp) 101.7 degrees Fahrenheit (F), pulse 140 beats per minute (bpm) -11:37 a.m. Temp 103.2 degrees F. -1:02 p.m. Temp 101.6 degrees F. -5:18 p.m. Temp 100.2 degrees F. 2/22/26 -9:50 a.m.- pulse (P) 109 bpm. -9:50 a.m. Temp 99.4 degrees F. -4:55p.m.- Temp 100.1 degrees F. 2/23/26 -8:50a.m. Temp 99.1 degrees F, P 102 bpm. -3:42 p.m. Temp 100 degrees F. R1's Physician Order Report indicated she was	F0580		

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F0580 SS = D	Continued from page 3 administered acetaminophen 1000 milligrams three times daily. R1's Progress Notes indicated the following: -2/19/26, R1 had not slept, was in and out of her room and hollering at her phone about murdering her babies. -2/19/26, R1 suddenly started yelling and crying stating "they want to take my babies from me" and stated her family member texted her and said she would see her in heaven at which point R1 was sobbing uncontrollably. -2/19/26, Interdisciplinary (IDT) discussed R1's behavior of throwing a water pitcher, wanted to cancel appointment and was hallucinating. -2/21/26, R1 stated she had been vomiting all night and stated she was in so much pain she could hardly move. -2/21/26, R1 was visibly shaking and cold in the morning. Vitals signs normal except for Temp which was 101 degrees F. Tylenol was given and Temp repeated and remained 101 degrees F. -2/22/26, R1 had episodes of incontinent diarrhea and was running a low-grade fever of 99 degrees F. R1 reported pain everywhere, was tearful and crying and stated she wanted to leave. -2/22/26, R1's had Temp 100.1 degrees F., Tylenol given. -2/23/26, IDT discussed R1's fevers over the weekend, feeling tired, refusing medications and verbal behaviors toward staff. Staff would assess R1 and contact provider if necessary. -2/23/26, R1 was lying in bed and reported not eating dinner and feeling very tired. Writer checked vitals at this time. Temp was 100 degrees F. -2/23/26, R1 did not eat dinner but ate some pudding. R1 did not want any medications. -2/24/26, R1 was shivering at this time stating she was cold. Temperature was 99.2 degrees F, color was pale with a grey hue, dark circles under her eyes. R1 stated she hurt all over and stated just did not feel well. Ambulance called and R1 was sent to emergency department (ED) for evaluation.	F0580		

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F0580 SS = D	Continued from page 4 -2/25/26, R1 had been transferred to hospital with diagnosis of sepsis. R1's ED Provider Notes dated 2/24/26, indicated R1 had been brought to the ED after becoming drowsier and unresponsive. R1's temperature was 102.8 degrees F. R1 had started a fever on Friday (2/20/26). Physical appearance indicated "ill-appearing," and "toxic-appearing." Cardiovascular indicated tachycardia (a resting heart rate that is too fast, typically over 100 bpm in adults, resulting from an abnormal electrical signal in the heart). ED course indicated intravenous (IV) fluids were started and R1 started to develop hypotension (low blood pressure) and R1 had GFR [glomerular filtration rate] a medical test that measures how well your kidneys filter blood, acting as a key indicator of kidney function) was quite low. R1 received IV antibiotics and had a urinary tract infection. Due to R1 showing signs of sepsis, she needed to be transferred to a higher level of care. Problems addressed included acute kidney injury, ureteral obstruction and sepsis with acute renal failure and septic shock. R1's Hospital discharge paperwork identified the principal problem as sepsis due to E-coli with acute organ dysfunction and septic shock and urinary tract infection secondary to obstructing left ureteral stone. During interview on 3/4/26 at 9:20 p.m., the physician said staff had not contacted her when R1 had the change of condition. The physician said people could have bladder stones for years but said when she developed a fever staff should have contacted her. The physician said the septic shock could have been avoided. During interview on 3/4/26 at 9:20 a.m., medical doctor (MD)-A confirmed staff had not notified her of R1's change of condition. MD-A stated she should have been contacted when R1 developed a fever. MD-A said R1's septic shock would have been avoided. During interview on 3/4/26 at 11:47 a.m., registered nurse (RN)-B stated staff should have notified the provider of R1's change of condition. Facility policy Change in Condition, Resident Examination and Evaluation dated 11/10/25, indicated when a significant change in the resident's physical, mental or psychological status is identified by the licensed nurse, or when there is a need to alter treatment significantly, the licensed nurse consults with the attending provider and notifies the resident	F0580		

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F0580 SS = D	Continued from page 5 representative. Notify the provider of change of condition and implement orders for treatment and appropriate monitoring as directed. Notify the provider of any abnormalities such as, but no limited to, abnormal vital signs, change in behavioral of neurological condition, worsening pain reported by the resident.	F0580		
F0684 SS = SQC-J	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 identify and act on a change of condition for 1 of 3 residents (R1) who was care planned for potential infections, had a fever and was experiencing hallucinations which was an atypical symptom. This delay in treatment resulted in an immediate Jeopardy (IJ) for R1 when she was diagnosed with sepsis and was hospitalized. The IJ began on 2/21/26, when R1's vital signs indicated a temperature of 101.7 degrees Fahrenheit (F) and she was demonstrating other signs of illness such as vomiting, visible shaking, hallucinations, disruptive behavior, reports of pain, and crying with no nursing assessment conducted and the provider was not contacted. R1's symptoms continued until she was brought to the emergency department (ED), had a temperature of 102.8 degrees F, a physical appearance described as ill and toxic appearing and was diagnosed with septic shock and had to be hospitalized. /The administrator was notified of the immediate jeopardy at 4:30 p.m. on 3/4/26. The immediate jeopardy was removed on 3/5/26, but noncompliance remained at the lower scope and severity level of /D, /which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's annual Minimum Data Set dated 12/26/25, identified intact cognition and indicated she did not display hallucinations, delusions or behaviors. R1’s care plan identified a self-care	F0684	During the complaint survey process, it was noted that the facility failed to identify and act on a change of condition for 1 of 3 residents (R1) who was care planned for potential infections, had a fever and was experiencing hallucinations which was an atypical symptom. R1 was hospitalized and treated for sepsis. Upon identification of Immediate Jeopardy on 3/4/26, the facility immediately implemented corrective actions. Immediate education to all licensed nurses on recognition of sepsis symptoms, atypical presentations (including hallucinations), removal of bias related to psychiatric diagnoses. Immediate review of all residents for signs/symptoms of infection or change in condition. Immediate implementation of enhanced monitoring protocols for any resident with abnormal findings All residents have the ability to be affected by this deficient practice. On 3/4/26–3/5/26, the facility completed a 100% house-wide assessment of all residents including vital signs review, infection symptoms, behavioral changes, pain and intake status. Any identified concerns were addressed immediately with provider notification and interventions. No additional residents were identified as being in Immediate Jeopardy. The facility implemented an Infection Screening Tool to be used with any resident exhibiting a significant change in condition. The facility revised nursing assessment protocols to require full assessment for any abnormal vital signs and documentation of clinical decision-making. The facility implemented a mandatory escalation pathway: Nurse !’ Provider & Nurse !’ Nurse Manager !’ DON. The facility established a weekend clinical oversight process, including on-call nurse manager review of	04/03/2026

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F0684 SS = SQC-J	Continued from page 6 deficit and a potential for infection related to urinary incontinence. The care plan directed staff to update the provider as needed. The care plan indicated R1 was alert and oriented and independent in making decisions. R1's Vitals Report identified the following: 2/21/26 -10:32 a.m. temperature (Temp) 101.7 degrees Fahrenheit (F), pulse 140 beats per minute (bpm) -11:37 a.m. Temp 103.2 degrees F. -1:02 p.m. Temp 101.6 degrees F. -5:18 p.m. Temp 100.2 degrees F. 2/22/26 -9:50 a.m.- pulse (P) 109 bpm. -9:50 a.m. Temp 99.4 degrees F. -4:55p.m.- Temp 100.1 degrees F. 2/23/26 -8:50a.m. Temp 99.1 degrees F, P 102 bpm. -3:42 p.m. Temp 100 degrees F. R1's Physician Order Report indicated she was administered scheduled, acetaminophen 1000 milligrams three times daily for pain. R1's Progress Notes indicated the following: -2/19/26, R1 had not slept, was in and out of her room and hollering at her phone about murdering her babies. -2/19/26, R1 suddenly started yelling and crying stating "they want to take my babies from me" and stated her family member texted her and said she would see her in heaven at which point R1 was sobbing uncontrollably. -2/19/26, Interdisciplinary team (IDT) discussed R1's behavior of throwing a water pitcher, wanted to cancel appointment and was hallucinating. -2/21/26, R1 stated she had been vomiting all night and stated she was in so much pain she could hardly move. -2/21/26, R1 was visibly shaking and cold in the morning. Vitals signs normal except for Temp which was 101 degrees F. Tylenol was given and Temp repeated and remained 101 degrees F. -2/22/26, R1 had episodes of incontinent diarrhea and was running a low-grade fever of 99 degrees F. R1 reported pain everywhere, was tearful and crying	F0684	Continued from page 6 changes in condition. The facility holds a daily clinical stand-up meeting to review high-risk residents. An audit will be conducted for timely identification of change in condition, appropriate assessment, provider notification, and implementation of interventions on all residents daily x 4 weeks, then all residents daily, M-F x 8 weeks then as needed thereafter as determined by quality council for continued compliance. DON/DON Designee is responsible for compliance.	

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F0684 SS = SQC-J	Continued from page 7 and stated she wanted to leave. -2/22/26, R1's had Temp 100.1 degrees F., Tylenol given. -2/23/26, IDT discussed R1's fevers over the weekend, feeling tired, refusing medications and verbal behaviors toward staff. Staff would assess R1 and contact provider if necessary. -2/23/26, R1 was lying in bed and reported not eating dinner and feeling very tired. Writer checked vitals at this time. Temp was 100 degrees F. -2/23/26, R1 did not eat dinner but ate some pudding. R1 did not want any medications. -2/24/26, R1 was shivering at this time stating she was cold. Temperature was 99.2 degrees F, color was pale with a grey hue, dark circles under her eyes. R1 stated she hurt all over and just did not feel well. Ambulance called and R1 was sent to emergency department (ED) for evaluation. -2/25/26, R1 had been transferred to hospital with diagnosis of sepsis. R1's ED Provider Notes dated 2/24/26, indicated R1 had been brought to the ED after becoming drowsier and unresponsive. R1's temp was 102.8 degrees F. R1 had started a fever on Friday (2/20/26). Physical appearance indicated "ill-appearing," and "toxic-appearing." Cardiovascular indicated tachycardia (a resting heart rate that is too fast, typically over 100 bpm in adults, resulting from an abnormal electrical signal in the heart). ED course indicated intravenous (IV) fluids were started and R1 started to develop hypotension (low blood pressure) and R1 had GFR [glomerular filtration rate] /a medical test that measures how well your kidneys filter blood, acting as a key indicator of kidney function) was quite low. R1 received IV antibiotics and had a urinary tract infection. Due to R1 showing signs of sepsis, she needed to be transferred to a higher level of care. Problems addressed included acute kidney injury, ureteral obstruction and sepsis with acute renal failure and septic shock. R1's Hospital discharge paperwork identified the principal problem as sepsis due to E-coli with acute organ dysfunction and septic shock and urinary tract infection secondary to obstructing left ureteral stone. During observation and interview on 3/3/26 at 3:03 p.m., /R1 was seated in a recliner chair in her room. R1 stated the Friday before she went to the hospital she had gotten her pills, then started throwing up. R1 stated prior to going to the hospital, she really did not remember anything. R1 said at the hospital they told her she had kidney stone and placed a stent and said she had been really sick. During interview on 3/3/26 at 4:39 p.m., registered nurse (RN)-D stated she had worked with R1 and said she had not identified anything out of the ordinary other than R1 complained of feeling weak and had been running a	F0684		

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F0684 SS = SQC-J	Continued from page 8 low-grade fever. RN-D said she contributed her symptoms to R1 possible having influenza. RN-D said one morning when R1's temperature was checked it was 98.2 degrees F, and with the presumption of R1 having influenza it was thought maybe R1 was getting over it. RN-D stated the nurses had conversations between incoming and outgoing shifts about R1's condition and she had been told at the beginning of her shift on Monday, R1 was not feeling better and if it continued she night need to be sent to the ED. RN-D said the morning R1 was sent to the ED, she had checked on R1 and said her color did not look good and she complained of having pain all over so she had called 911. During interview on 3/4/26 at 9:20 a.m., medical doctor (MD)-A said staff had not contacted her when R1 had the change of condition. The MD stated people could have bladder stones for years with urinary tract infections that came and went but said when stone pain started it was important to be seen right away. MD-A stated the facility should have contacted her when R1 developed a fever. Adding, if they had, R1's septic shock would have been avoided. During interview on 3/4/26 at 10:01 a.m., nurse practitioner (NP) stated R1 arrived at the ED early in the morning and had been barely responsive. NP stated the ED staff were about to intubate but R1 perked up with intravenous fluids and vasopressors. NP stated R1 was very sick and said her blood pressure had dropped which indicated the use of vasopressors and R1's kidneys were in bad shape. The NP indicated R1 had a large stone she could not pass on her own with puss behind it that was drained and, while the stone would had not have been avoidable, the sepsis and unnecessary pain could have been prevented if R1 had been sent to the ED sooner. During interview on 3/4/26 at 10:36 a.m., RN-C stated if a resident displayed a change of condition, she would start with checking vital signs and comparing them to the resident's baseline, completing a general assessment and then reporting to the nurse managers. RN-C said prior to R1 going to the hospital, she had come to work in the morning and R1 had reported not sleeping. RN-C stated R1 had been crying and talking about her daughter. RN-C said R1 had been hallucinating, which was not normal. RN-C stated she had spoken to R1's family member (FM) and RN-A about R1 that day. During interview on 3/4/26 at 11:24 a.m. RN-A said R1's change in condition happened over the weekend and said the IDT was not there on the weekend which was part of the problem. RN-A said R1 was discussed during the IDT meeting on Monday but said they did not review the progress notes or R1's vital signs.	F0684		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0684 SS = SQC-J	Continued from page 9 During interview on 3/4/26 at 11:47 a.m., RN-B said when a change of condition occurred, depending on the change, staff should assess and monitor. RN-B said she had not assessed R1 on 2/23/26, following the IDT discussion and said she had gone to R1's room but she had been asleep and her temp had been down to 99.1 degrees F. RN-B stated she felt the IDT missed R1's change of condition because her diagnosis of Bipolar and previous behaviors had masked the change and said it had interfered with their judgement. RN-B further stated staff should have notified the physician about R1's elevated temperature over the weekend. Facility policy Change in Condition, Resident Examination and Evaluation dated 11/10/25, indicated a thorough resident examination will capture any abnormalities in health status, physical function and acute change of condition. Procedure: Licensed nurses within their scope of practice standards, evaluate for a significant change of condition through direct observation/physical examination that is outside of baseline findings including interview or report from other staff. Obtain vital signs. Notify the provider of change of condition and implement orders for treatment and appropriate monitoring as directed. Notify the provider of any abnormalities such as, but no limited to, abnormal vital signs, change in behavioral of neurological condition, worsening pain reported by the resident. The immediate jeopardy that began on /2/21/26 /was removed on 3/5/26, after the facility implemented a systemic plan that included the following actions: Review of Policy and Procedures related to Change in Condition and Physician Notification. Reviewed all residents for a potential change in condition. Education to nursing staff on /identification of policies and procedures related to change of condition and resident monitoring, qualifying factors for a change of condition as well as assessment of the resident symptoms (removing bias of resident behaviors/baseline) and timely notification of Physician and treatment of resident symptoms.	F0684		
F0882 SS = F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology,	F0882	During the complaint survey process, it was noted that the facility failed to ensure the infection preventionist (IP) completed the required training for the role of IP. No residents were directly affected by this deficiency and would not be directly affected, as this deficiency relates to staff qualifications. The designated Infection Preventionist (IP) is enrolled in required infection prevention training program and will have the training completed by 4/1/2026.	04/03/2026

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 03/05/2026

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F0882 SS = F	Continued from page 10 epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the infection preventionist (IP) completed the required training for the role of IP. Findings include: RN-B's record of completed training was reviewed and lacked evidence of training related to the role of IP. During interview on 3/5/26 at 2:22 p.m., registered nurse (RN)-B stated she was the facility designated IP. RN-B stated she had started the required training but had not had time to finish. Facility policy Infection Preventionist Role dated 8/2023, indicated the IP or designee is responsible for directing the infection prevention and control program within the facility. The IP should have a background and training appropriate for carrying out these responsibilities, have a primary professional training in nursing, medical technology, microbiology, epidemiology or other related field, be qualified by education, training, certification or experience, and have completed specialized training in infection prevention and control.	F0882	Continued from page 10 A secondary designee was identified and enrolled in training to ensure coverage. The facility implemented a tracking system for required certifications and trainings. An audit will be conducted to review IP training compliance annually and when there is any position turnover and report findings to QAPI committee. HR/designee will maintain ongoing tracking of required credentials. Administrator is responsible for compliance.	
F0943 SS = D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-	F0943	During the complaint survey process, it was noted that the facility failed to ensure annual abuse training was completed for 2 or 10 staff reviewed for training. No residents were identified as being affected. A facility-wide audit of all staff education records was completed on 3/6/26 to identify any staff with incomplete abuse training.	04/03/2026

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F0943 SS = D	Continued from page 11 §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure annual abuse training was completed for 2 of 10 staff reviewed for training. Findings Include: Nursing assistant (NA)-A had a hire date of 11/7/25. NA-A's record of Completed Training printed 3/5/26, indicated she had not completed annual abuse training. Registered nurse (RN)-B had a hire date of 8/28/24. RN-B's record of Completed Training printed 3/5/26, indicated she had not completed annual abuse training since 8/28/24. During interview on 3/5/26 at 1:41 p.m., the human resources manager (HRM) stated the mangers were responsible to ensure their staff completed training. The HRN said the corporate office sent messages quarterly regarding required trainings and she reminded the managers. The HRM said she did not track who had or had not completed required training. Facility policy Regulatory and Compliance Education dated 5/1/24, indicated each community should assign an associate the responsibility of the super registrar role. This person is to manage the tracking of the training system. Assigned "hire" courses should be completed before an associate works independently on the floor. "Annual" requirements are established according to licensure, certification and/or role-based requirements and are assigned quarterly.	F0943	Continued from page 11 All identified staff immediately completed required abuse training prior to working their next scheduled shift. The facility has assigned a designated training compliance coordinator (“super user”) responsible for monitoring completion, sending reminders, escalating non-compliance, and managers are required to review training compliance monthly. An audit will be conducted for training compliance weekly x 4 weeks then monthly x 2 months then as needed thereafter as determined by quality council for continued compliance. HR/Designee is responsible for compliance.	

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 3/3/26 through 3/5/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure. The following complaints were reviewed during the survey.	20000		03/24/2026

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/05/2026**

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20000	Continued from page 1 H55027340C (2788982). H55027600C (2792265). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		