



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 23, 2026

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

RE: CCN: 245426
Cycle Start Date: August 26, 2026

Dear Administrator:

On September 22, 2026, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



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September 23, 2026

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

Re: Reinspection Results
Event ID: 342C09-H2

Dear Administrator:

On September 22, 2026 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 26, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
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An equal opportunity employer.



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September 10, 2026

Administrator

BENEDICTINE LIVING COMMUNITY OWATONNA

2255 30TH STREET NW

OWATONNA, MN 55060

RE: CCN: 245426

Cycle Start Date: August 26, 2026

Dear Administrator:

On August 26, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us

Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public

Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by November 26, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 26, 2027 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will

not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

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September 10, 2026

Administrator

BENEDICTINE LIVING COMMUNITY OWATONNA

2255 30TH STREET NW

OWATONNA, MN 55060

Re: State Nursing Home Licensing Orders

Event ID: 342C09-H1

Dear Administrator:

The above facility survey was completed on August 26, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245426		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/26/2026	
NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY OWATONNA				STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW , OWATONNA, Minnesota, 55060			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 8/25/26, and 8/26/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54263669C (3136421) with a deficiency issued at F689. 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			09/10/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to complete a comprehensive fall analysis to identify root cause/causal factors to prevent and/or reduce the risk of falls from self-transferring, failed to follow the care plan, and			F0689	F689 R2's fall risk assessment and current fall-prevention interventions were reviewed. The care plan was updated to address resident transfer needs and current fall-prevention interventions. Residents who experienced a fall within the previous 30 days and residents identified by nursing staff as having known self-transfer behaviors were reviewed to ensure appropriate interventions were implemented and the care plan accurately reflected current transfer assistance needs and fall-prevention interventions. Ongoing, all newly admitted residents identified to be at risk for falls will be reviewed during the facility IDT meeting to ensure resident-specific interventions are implemented and transfer assistance needs are accurately reflected in the care plan.		09/10/2026

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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F0689 SS = D	Continued from page 1 failed to timely revise the care plan with immediate fall interventions to prevent/mitigate the risk of re-current falls for 1 of 3 residents (R2) reviewed for falls. Findings include: R2’s face sheet identified diagnoses of unsteadiness on feet, repeated falls, and muscle weakness. R2’s annual Minimum Data Set (MDS) dated 6/7/26, R2 had severe cognitive impairment, no difficulties with hearing or speech, and wore glasses. R2 did not have inattention, or disorganized thinking. R2 utilized a walker and wheelchair for mobility. R2 required partial/moderate assistance with toileting hygiene, upper/lower body dressing, putting on/taking off footwear, sit to lie/lie to sit, and walking. R2 required supervision/touching assistance to move from sitting to standing, and toilet transfers. R2 was occasionally incontinent of bladder and frequently incontinent of bowel. R2’s Mobility care plan dated 1/22/25, identified R2 was limited in ability to transfer self- due to weakness, unsteady gait, and poor endurance. Interventions included assist of one with gait belt, family member (FM)-A and B were able to transfer R2 per therapy, follow therapy recommendations, keep call light easily accessible. R2’s care plan dated 2/11/25, identified R2 was limited with ambulation due to weakness. Interventions included on 6/5/25, assist of one staff to stand, pivot with gait belt to/from wheelchair. Walk with front wheeled walker and gait belt distance as tolerated, wheelchair to follow. R2’s Falls care plan 1/22/25, identified R2 was at risk for falls due to weakness and unsteady gait. The interventions included: 1/22/25-educate on prevention/reduction precautions per facility protocol; 5/30/25- therapy consult for transfer training and assessment, follow therapy recommendation, and stop sign to remind R2 to call for help and wait for assistance, and educate on prevention/reduction precautions per facility protocol. 6/5/25-pancake call light with fluorescent tape, room rearranged with recliner moved closer to bathroom, and wheelchair next to bed or recliner at all times,			F0689	Continued from page 1 All licensed nursing staff will be educated on the Integrated Falls Management Policy (POL_NS303); including the implementation of resident-specific interventions and care plan revisions. All facility nursing assistants will be educated on Integrated Falls Management Policy (POL_NS303); including following resident-specific fall interventions per the plan of care and reporting resident self-transfers and falls. DON or designee will complete an audit of residents with falls weekly for 4 weeks and monthly for 2 months to verify that fall risk assessments have been completed, resident-specific intervention have been implemented, care plan has been revised as indicated, and interventions were communicated to staff. Identified concerns will be corrected promptly and additional education provided as indicated. Audit results will be reviewed through QAPI to determine the need for further action or until substantial compliance has been met.		09/10/2026

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F0689 SS = D	Continued from page 2 7/2/25-R2 was not to be left alone in bathroom, and toilet R2 before and after meals, 8/5/25-leave bathroom light on, 10/8/25-pharmacy review due to blood pressures, 11/5/25-bed to be opened (covers pulled back) around 4:00 p.m. every afternoon, 12/8/25-Christmas tree moved away from window and closer to R2, and ensure proper footwear at all times, R2’s fall event report dated 2/18/26 at 1:05 p.m. identified R2 had an unwitnessed fall in bathroom; she was found on the bathroom floor lying on her left side with her pants and briefs down below her buttocks. R2 had reported she was trying to use the bathroom. R2 had been toileted at 11:45 a.m., wearing shoes, with no environmental risk factors identified. Fall risk factors checked were gait imbalance, hypotension, impaired memory, lethargic/drowsy, and R2 required one staff assistance with assistive device. Additionally, R2 had an emesis, didn't feel good and was sent to the emergency department (ED). R2 returned to the facility on 2/20/26 and started physical therapy. The report indicated staff would review toileting needs and adjust toileting plan. In review of R2’s care plan there was no indication the toileting plan was revised or an immediate intervention to prevent/decrease the risk for falls related to self-transferring and toileting and no indication a comprehensive assessment was completed to determine R2’s level of supervision. R2’s interdisciplinary team (IDT) progress note dated 2/24/26, identified R2 fell while attempting to self-transfer to the bathroom after independently leaving the dining room and returning to her room. R2 did not request assistance prior to the fall. R2 had been toileted prior to lunch. R2 had been assessed by therapy upon return from hospital. As proactive fall interventions, anti-roll back brakes were added to R2’s wheelchair. Additionally, a large yellow stop-sign banner was placed across the bathroom door to cue R2 to stop and request assistance before entering. R2 will continue to be monitored for safety and fall risk. R2’s care plan was revised on 2/24/26 to include			F0689			09/10/2026

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F0689 SS = D	Continued from page 3 the intervention of anti-rollback brakes applied to wheelchair, and yellow stop sign banner across bathroom door. R2’s progress note dated 6/4/26, identified nursing assistant (NA) walked to the toilet with NA using walker and stated she was feeling short of breath and dizzy. When R2 was done on the toilet, she started to get up off the toilet riser before the NA was right next to her, R2 began to fall after standing and the NA, who was in the bathroom with her, was able to lower her to the floor and have her sit on the floor. Intervention put in place to use the wheelchair for transfers and toileting for the time being until she regains her stamina. R2’s Fall Event report dated 6/4/26, identified R2 had a witnessed fall in the bathroom after the aide left R2 alone in the bathroom sitting on the toilet while the NA stood in the bathroom doorway (which was not in accordance to the care plan intervention dated 7/2/25 that directed R2 was not to be left alone in bathroom...” R2 was lowered to the floor by NA. NA stated R2 began to get up off the toilet before NA was right next to her. Fall risk factors included recent illness, active infection, and loose stools. R2 transferred at baseline with assistance of one staff with gait belt and device. R2 was alert at time of fall. Immediate intervention implemented was a recommendation to use wheelchair only until R2 felt better. R2’s IDT progress note dated 6/5/26, identified IDT reviewed R2’s fall incident that occurred during transfer/ambulation following toileting. R2 demonstrated weakness upon standing and was safely lowered to the floor by NA. Team discussion identified recent illness and associated weakness as a contributing factor. Immediate intervention implemented was use of a wheelchair for nighttime mobility to reduce fall risk during periods of weakness. Orders requested for therapies to evaluate and treat. R2 will continue to be monitored, and effectiveness of interventions will be evaluated through ongoing assessment and IDT review. The IDT note did not identify the care plan intervention that directed not to leave R2 alone in the bathroom was not followed which did not address the causal factor of R2 attempting to self-transfer. R2’s falls care plan dated 6/5/26, identified an intervention to utilize wheelchair at night for mobility.			F0689			09/10/2026

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F0689 SS = D	Continued from page 4 During an interview on 8/25/26 at 1:30 p.m., NA-A stated R2 frequently self-transferred. Staff would clip the call light on R2’s clothes, keep the wheelchair by the bed, and there were signs in R2’s room to remind her not to self-transfer “she doesn’t pay much attention to them”. During an interview on 8/26/26 at 9:40 a.m., NA-B stated R2 self-transferred “quite a bit”. The facility put a stop sign in front of the bathroom door and bright pink tape on the call light. R2 was not always good about remembering to use the call light, even with the pink tape. NA-B stated she would occasionally just “pop-in” and check on R2. During an interview on 8/26/26 at 10:10 a.m., NA-D stated R2 self-transferred “frequently” but felt during the day shift she could “catch her before” she attempted because NA-D knew when R2 woke up and would offer toileting. NA-D stated during shift reports, the night shift staff would report that R2 self-transferred 2-3 times every night. In review of R2’s record between 2/18/26 and 8/4/2026, despite multiple staff reports of R2’s repeated self-transfers, there was no indication of documentation that tracked R2’s self-transfers, nor evident of a comprehensive assessment for level of supervision to prevent or mitigate R2’s risk of falls related to self-transfers. R2’s progress note dated 8/5/26 at 5:00 p.m., identified R2 had been with her husband and daughter in the cojoining room visiting. Daughter left. R2’s wheelchair was located sitting in front of the recliner. R2 had fallen and was observed sitting on her bottom with her back to the bed and feet toward the wheelchair. R2 stated she was trying to get in the recliner. R2’s Safety Event–Fall dated 8/5/26 at 5:53 p.m. identified that R2 experienced a fall in her room and was found on the floor by a nursing assistant. Documentation assessment sections were not completed, including the activity at the time of the fall and the staff description of how the fall occurred. R2’s description of fall indicated she wanted to get up from wheelchair and go into her recliner. R2 sustained no injuries. She had last been toileted at 4:30 p.m. and was wearing gripper socks. R2 was noted to be alert and confused. The			F0689			09/10/2026

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F0689 SS = D	Continued from page 5 intervention to prevent further falls was to make sure to alert staff to assist her to the recliner. However, this intervention was not further defined to identify frequency of how often and when staff were supposed to assist R2 transferring before she attempted self-transferred. During an interview on 8/26/26 at 9:48 a.m., nursing assistant (NA)-C stated R2 attempted to transfer independently every day and on every shift, although her abilities varied from day to day. Staff attempted to prevent falls by placing signs in R2's room, explaining the use of the call light, securing the call light within her reach, and positioning her walker or wheelchair nearby while she was in bed or seated in a chair. R2 understood these instructions to some extent but did not retain the information and had to be reminded each time she was positioned because "she always acts like it is the first time she has heard the information." NA-C stated staff were not given specific timeframes for checking on R2 and were instructed only to check on her during the shift. NA-C stated that on 8/5/26, R2 had been visiting outside with family at approximately 2:00 p.m. NA-C had not assisted R2 before the fall. After hearing yelling from R2's room around 4:45 p.m., NA-C entered and observed R2 and her husband on the floor on opposite sides of the room. R2 was lying next to her bed and yelling for her husband to help her stand. During a phone interview on 8/26/26 at 1:14 p.m., registered nurse (RN)-A stated on 8/5/26, family was visiting R2 and left shortly after the afternoon shift began. Around supper time, RN-A was called to R2's room because she was on the floor. RN-A was unsure when R2 had been toileted last. R2 was on the floor with her feet facing the bathroom and her top half was at the end of the bed. R2 self-transfers "pretty frequently, little stinker". RN-A stated R2 will frequently be in her recliner and decide to self-transfer to the bathroom. Normally, staff attempt to go in the room after family leave and get R2 situated to avoid her self-transferring. R2's progress note dated 8/6/26, at 12:22 a.m., identified R2 denied pain from fall. Moves all extremities well without limitation or pain. R2 was directed to use call light if she needed anything, it was clipped to pajama top for easy access. R2's IDT progress note dated 8/6/26 at 3:27 p.m., identified IDT met to review R2's recent fall. R2 remained at an increased risk for falls due to recent hospitalization for ulcerative pancolitis (also called colitis) with resulting generalized weakness and			F0689			09/10/2026

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F0689 SS = D	Continued from page 6 history of recurrent falls. R2 was left unattended in the wheelchair in her room following a visit with family and attempted to self-transfer independently into the recliner, resulting in a fall. New intervention: family to notify staff prior to leaving so assistance could be provided promptly and not leave R2 unattended following visits. R2’s care plan was revised on 8/6/26, to include the aforementioned intervention however, did not address the level of supervision to prevent R2’s self-transfers. R2’s Fall Risk (Acuity) and Functional Limitation Range of Motion (ROM) dated 8/7/26, identified R2 had intermittent confusion, poor recall, judgement, and safety awareness. R2 had adequate vision, required use of assistive devices, had impaired mobility and/or assist with toileting. R2 took antidepressants, and antihypertensives. R2 had a medication change in the past five days which was an antibiotic post hospital. Blood pressure taken while lying and standing was not completed and recorded as unable to measure as resident could not stand. R2 had a history of three or more falls. R2 had a total fall risk score of 16 with a level of At Risk. During an interview on 8/25/26 at 12:30 p.m., family members (FM)-A and FM-B were present and in R2’s room. FM-B stated R2 had memory issues and falls. R2 did not ask for help. Two weeks ago, R2 fell when she attempted to move herself from one location to another. R2 had “creative Alzheimer's”, and does not listen or remember. FM-B stated the family was contemplating R2 being moved to a room closer to the nurses station and wondered if an alarm would assist staff when she tried to self-transfer. R2 would always self-transfer because she did not remember she could not do things independently. During an interview on 8/26/26 at 9:19 a.m., R2 was in the recliner. R2 stated she had been married for 35 years but her and her husband had been together for 17 years. When questioned about her fall on 8/5/26, R2 stated her husband had fallen while attempting to get out of bed and she went to help him “I’m as stable as nobody” and also fell. “Thank goodness my daughter came”. R2 then stated “well, actually, we were trying to get to each other’s room that’s why I came down and fell over and then [FM-A] came and we got it all put together”. R2 stated “I can transfer myself. I hope that will last a while”. R2 stated “they” wanted her to have someone with when she went to the bathroom. R2			F0689			09/10/2026

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F0689 SS = D	Continued from page 7 picked up her call light from the overbed table next to her “I got a little clock here that works, I push it to the right number and they come. They are very good about that”. During a follow-up interview on 8/26/26 at 1:45 p.m., NA-B stated NA’s reported R2’s self-transfers to the nurse whenever she would self-transfer but the NA’s did not have anywhere in the chart they would document it. During an interview on 8/26/26 at 1:50 p.m., NA-C stated she would write down all the times R2 self-transferred on the shift she worked and give the paper to the nurse at the end of the shift. NA-C was unaware what the nurse would do with the information after she provided it. During an interview on 8/26/26 at 12:09 p.m., licensed practical nurse (LPN)-A stated R2 self-transferred 2-3 times per day on the day shift and the self-transfers occurred more when R2 was out of bed than when she was in bed. LPN-A stated the NA’s would be able to give a better answer on how often R2 self-transferred. During a follow-up interview on 8/26/26 at 1:40 p.m., LPN-A stated NA’s are educated to tell the nurse on duty if R2 was self-transferring and nurses were supposed to make a progress note about it. LPN-A stated NA’s could meet R2’s needs and she could fall two minutes later. When LPN listened to night shift report they state that a lot of the times R2 would say she was fine when they checked on her and when they go back to the room she had self-transferred to the bathroom. When questioned if R2’s self-transfers were documented in the nurses progress notes, LPN stated “Oh, God, no, probably not”. During an interview on 8/25/26 at 11:15 a.m., director of nursing (DON) stated during facility review of incident, falls were reviewed from 8/2025-8/2026, to ensure all information was accurate. Education had been provided to all staff and the specific NA involved. During an interview on 8/26/26 at 2:07 p.m., DON and regional nurse consultant (RNC)-A stated the facility did not have an assessment for self-transfers. R2’s fall in February was from self-transferring. Keeping the wheelchair next to wherever she is at was to help make her environment as safe as possible. R2 was not to be left alone in the bathroom. Night shift provided every two-hour rounding, and during the day and evening			F0689			09/10/2026

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F0689 SS = D	Continued from page 8 shift, staff would go in the room frequently to check on R2's husband and would check on R2 at the same time, however, R2's husband had recently passed away. DON conceded there was no intervention for supervision to prevent self-transfer of R2, and self-transfers were an issue that was not specifically addressed to decrease the risk of falls for R2. The facility Integrated Fall Management policy dated 9/2023, identified the purpose of the policy was to complete: fall risk assessment, identification and implementation of appropriate interventions as necessary, to maintain resident safety, prevent falls and reduce further injury from falls.			F0689			09/10/2026

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/25/26, and 8/26/26, 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 order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H54263669C (3136421) with a licensing order issued at: 0830.			20000			09/10/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

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20000	Continued from page 1 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html 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 PAGEe reviewed these orders and identify the date when they will be completed.		20000			09/10/2026	
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		20830	F689 R2's fall risk assessment and current fall-prevention interventions were reviewed. The care plan was updated to address resident transfer needs and current fall-prevention interventions. Residents who experienced a fall within the previous 30 days and residents identified by nursing staff as having known self-transfer behaviors were reviewed to ensure appropriate interventions were		09/10/2026	

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20830	Continued from page 2 the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to complete a comprehensive fall analysis to identify root cause/causal factors to prevent and/or reduce the risk of falls from self-transferring, failed to follow the care plan, and failed to timely revise the care plan with immediate fall interventions to prevent/mitigate the risk of re-current falls for 1 of 3 residents (R2) reviewed for falls. Findings include: R2's face sheet identified diagnoses of unsteadiness on feet, repeated falls, and muscle weakness. R2's annual Minimum Data Set (MDS) dated 6/7/26, R2 had severe cognitive impairment, no difficulties with hearing or speech, and wore glasses. R2 did not have inattention, or disorganized thinking. R2 utilized a walker and wheelchair for mobility. R2 required partial/moderate assistance with toileting hygiene, upper/lower body dressing, putting on/taking off footwear, sit to lie/lie to sit, and walking. R2 required supervision/touching assistance to move from sitting to standing, and toilet transfers. R2 was occasionally incontinent of bladder and frequently incontinent of bowel. R2's Mobility care plan dated 1/22/25, identified R2 was limited in ability to transfer self- due to weakness, unsteady gait, and poor endurance. Interventions included assist of one with gait belt, family member (FM)-A and B were able to transfer R2 per therapy, follow therapy recommendations, keep call light easily accessible. R2's care plan dated 2/11/25, identified R2 was limited with ambulation due to weakness. Interventions included on 6/5/25, assist of one staff to stand, pivot with gait belt to/from wheelchair. Walk with front wheeled walker and gait belt distance as tolerated, wheelchair to follow. R2's Falls care plan 1/22/25, identified R2 was at risk for falls due to weakness and unsteady gait. The interventions included: 1/22/25-educate on prevention/reduction precautions per facility protocol; 5/30/25- therapy consult for transfer training and			20830	Continued from page 2 implemented and the care plan accurately reflected current transfer assistance needs and fall-prevention interventions. Ongoing, all newly admitted residents identified to be at risk for falls will be reviewed during the facility IDT meeting to ensure resident-specific interventions are implemented and transfer assistance needs are accurately reflected in the care plan. All licensed nursing staff will be educated on the Integrated Falls Management Policy (POL_NS303); including the implementation of resident-specific interventions and care plan revisions. All facility nursing assistants will be educated on Integrated Falls Management Policy (POL_NS303); including following resident-specific fall interventions per the plan of care and reporting resident self-transfers and falls. DON or designee will complete an audit of residents with falls weekly for 4 weeks and monthly for 2 months to verify that fall risk assessments have been completed, resident-specific intervention have been implemented, care plan has been revised as indicated, and interventions were communicated to staff. Identified concerns will be corrected promptly and additional education provided as indicated. Audit results will be reviewed through QAPI to determine the need for further action or until substantial compliance has been met.		09/10/2026

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20830	Continued from page 3 assessment, follow therapy recommendation, and stop sign to remind R2 to call for help and wait for assistance, and educate on prevention/reduction precautions per facility protocol. 6/5/25-pancake call light with fluorescent tape, room rearranged with recliner moved closer to bathroom, and wheelchair next to bed or recliner at all times, 7/2/25-R2 was not to be left alone in bathroom, and toilet R2 before and after meals, 8/5/25-leave bathroom light on, 10/8/25-pharmacy review due to blood pressures, 11/5/25-bed to be opened (covers pulled back) around 4:00 p.m. every afternoon, 12/8/25-Christmas tree moved away from window and closer to R2, and ensure proper footwear at all times, R2’s fall event report dated 2/18/26 at 1:05 p.m. identified R2 had an unwitnessed fall in bathroom; she was found on the bathroom floor lying on her left side with her pants and briefs down below her buttocks. R2 had reported she was trying to use the bathroom. R2 had been toileted at 11:45 a.m., wearing shoes, with no environmental risk factors identified. Fall risk factors checked were gait imbalance, hypotension, impaired memory, lethargic/drowsy, and R2 required one staff assistance with assistive device. Additionally, R2 had an emesis, didn’t feel good and was sent to the emergency department (ED). R2 returned to the facility on 2/20/26 and started physical therapy. The report indicated staff would review toileting needs and adjust toileting plan. In review of R2’s care plan there was no indication the toileting plan was revised or an immediate intervention to prevent/decrease the risk for falls related to self-transferring and toileting and no indication a comprehensive assessment was completed to determine R2’s level of supervision. R2’s interdisciplinary team (IDT) progress note dated 2/24/26, identified R2 fell while attempting to self-transfer to the bathroom after independently leaving the dining room and returning to her room. R2 did not request assistance prior to the fall. R2 had been toileted prior to lunch. R2 had been			20830			09/10/2026

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20830	Continued from page 4 assessed by therapy upon return from hospital. As proactive fall interventions, anti-roll back brakes were added to R2's wheelchair. Additionally, a large yellow stop-sign banner was placed across the bathroom door to cue R2 to stop and request assistance before entering. R2 will continue to be monitored for safety and fall risk. R2's care plan was revised on 2/24/26 to include the intervention of anti-rollback brakes applied to wheelchair, and yellow stop sign banner across bathroom door. R2's progress note dated 6/4/26, identified nursing assistant (NA) walked to the toilet with NA using walker and stated she was feeling short of breath and dizzy. When R2 was done on the toilet, she started to get up off the toilet riser before the NA was right next to her, R2 began to fall after standing and the NA, who was in the bathroom with her, was able to lower her to the floor and have her sit on the floor. Intervention put in place to use the wheelchair for transfers and toileting for the time being until she regains her stamina. R2's Fall Event report dated 6/4/26, identified R2 had a witnessed fall in the bathroom after the aide left R2 alone in the bathroom sitting on the toilet while the NA stood in the bathroom doorway (which was not in accordance to the care plan intervention dated 7/2/25 that directed R2 was not to be left alone in bathroom..." R2 was lowered to the floor by NA. NA stated R2 began to get up off the toilet before NA was right next to her. Fall risk factors included recent illness, active infection, and loose stools. R2 transferred at baseline with assistance of one staff with gait belt and device. R2 was alert at time of fall. Immediate intervention implemented was a recommendation to use wheelchair only until R2 felt better. R2's IDT progress note dated 6/5/26, identified IDT reviewed R2's fall incident that occurred during transfer/ambulation following toileting. R2 demonstrated weakness upon standing and was safely lowered to the floor by NA. Team discussion identified recent illness and associated weakness as a contributing factor. Immediate intervention implemented was use of a wheelchair for nighttime mobility to reduce fall risk during periods of weakness. Orders requested for therapies to evaluate and treat. R2 will continue to be monitored, and effectiveness of interventions will be evaluated through ongoing assessment and IDT review. The			20830			09/10/2026

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20830	Continued from page 5 IDT note did not identify the care plan intervention that directed not to leave R2 alone in the bathroom was not followed which did not address the causal factor of R2 attempting to self-transfer. R2’s falls care plan dated 6/5/26, identified an intervention to utilize wheelchair at night for mobility. During an interview on 8/25/26 at 1:30 p.m., NA-A stated R2 frequently self-transferred. Staff would clip the call light on R2’s clothes, keep the wheelchair by the bed, and there were signs in R2’s room to remind her not to self-transfer “she doesn’t pay much attention to them”. During an interview on 8/26/26 at 9:40 a.m., NA-B stated R2 self-transferred “quite a bit”. The facility put a stop sign in front of the bathroom door and bright pink tape on the call light. R2 was not always good about remembering to use the call light, even with the pink tape. NA-B stated she would occasionally just “pop-in” and check on R2. During an interview on 8/26/26 at 10:10 a.m., NA-D stated R2 self-transferred “frequently” but felt during the day shift she could “catch her before” she attempted because NA-D knew when R2 woke up and would offer toileting. NA-D stated during shift reports, the night shift staff would report that R2 self-transferred 2-3 times every night. In review of R2’s record between 2/18/26 and 8/4/2026, despite multiple staff reports of R2’s repeated self-transfers, there was no indication of documentation that tracked R2’s self-transfers, nor evident of a comprehensive assessment for level of supervision to prevent or mitigate R2’s risk of falls related to self-transfers. R2’s progress note dated 8/5/26 at 5:00 p.m., identified R2 had been with her husband and daughter in the cojoining room visiting. Daughter left. R2’s wheelchair was located sitting in front of the recliner. R2 had fallen and was observed sitting on her bottom with her back to the bed and feet toward the wheelchair. R2 stated she was trying to get in the recliner. R2’s Safety Event–Fall dated 8/5/26 at 5:53 p.m.			20830			09/10/2026

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20830	Continued from page 6 identified that R2 experienced a fall in her room and was found on the floor by a nursing assistant. Documentation assessment sections were not completed, including the activity at the time of the fall and the staff description of how the fall occurred. R2’s description of fall indicated she wanted to get up from wheelchair and go into her recliner. R2 sustained no injuries. She had last been toileted at 4:30 p.m. and was wearing gripper socks. R2 was noted to be alert and confused. The intervention to prevent further falls was to make sure to alert staff to assist her to the recliner. However, this intervention was not further defined to identify frequency of how often and when staff were supposed to assist R2 transferring before she attempted self-transferred. During an interview on 8/26/26 at 9:48 a.m., nursing assistant (NA)-C stated R2 attempted to transfer independently every day and on every shift, although her abilities varied from day to day. Staff attempted to prevent falls by placing signs in R2’s room, explaining the use of the call light, securing the call light within her reach, and positioning her walker or wheelchair nearby while she was in bed or seated in a chair. R2 understood these instructions to some extent but did not retain the information and had to be reminded each time she was positioned because “she always acts like it is the first time she has heard the information.” NA-C stated staff were not given specific timeframes for checking on R2 and were instructed only to check on her during the shift. NA-C stated that on 8/5/26, R2 had been visiting outside with family at approximately 2:00 p.m. NA-C had not assisted R2 before the fall. After hearing yelling from R2’s room around 4:45 p.m., NA-C entered and observed R2 and her husband on the floor on opposite sides of the room. R2 was lying next to her bed and yelling for her husband to help her stand. During a phone interview on 8/26/26 at 1:14 p.m., registered nurse (RN)-A stated on 8/5/26, family was visiting R2 and left shortly after the afternoon shift began. Around supper time, RN-A was called to R2’s room because she was on the floor. RN-A was unsure when R2 had been toileted last. R2 was on the floor with her feet facing the bathroom and her top half was at the end of the bed. R2 self-transfers “pretty frequently, little stinker”. RN-A stated R2 will frequently be in her recliner and decide to self-transfer to the bathroom. Normally, staff attempt to go in the room after family leave and get R2 situated to avoid her self-transferring. R2’s progress note dated 8/6/26, at 12:22 a.m.,			20830			09/10/2026

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NAME OF PROVIDER OR SUPPLIER BENEDICTINE LIVING COMMUNITY OWATONNA				STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30TH STREET NW , OWATONNA, Minnesota, 55060			
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20830	Continued from page 7 identified R2 denied pain from fall. Moves all extremities well without limitation or pain. R2 was directed to use call light if she needed anything, it was clipped to pajama top for easy access. R2's IDT progress note dated 8/6/26 at 3:27 p.m., identified IDT met to review R2's recent fall. R2 remained at an increased risk for falls due to recent hospitalization for ulcerative pancolitis (also called colitis) with resulting generalized weakness and history of recurrent falls. R2 was left unattended in the wheelchair in her room following a visit with family and attempted to self-transfer independently into the recliner, resulting in a fall. New intervention: family to notify staff prior to leaving so assistance could be provided promptly and not leave R2 unattended following visits. R2's care plan was revised on 8/6/26, to include the aforementioned intervention however, did not address the level of supervision to prevent R2's self-transfers. R2's Fall Risk (Acuity) and Functional Limitation Range of Motion (ROM) dated 8/7/26, identified R2 had intermittent confusion, poor recall, judgement, and safety awareness. R2 had adequate vision, required use of assistive devices, had impaired mobility and/or assist with toileting. R2 took antidepressants, and antihypertensives. R2 had a medication change in the past five days which was an antibiotic post hospital. Blood pressure taken while lying and standing was not completed and recorded as unable to measure as resident could not stand. R2 had a history of three or more falls. R2 had a total fall risk score of 16 with a level of At Risk. During an interview on 8/25/26 at 12:30 p.m., family members (FM)-A and FM-B were present and in R2's room. FM-B stated R2 had memory issues and falls. R2 did not ask for help. Two weeks ago, R2 fell when she attempted to move herself from one location to another. R2 had "creative Alzheimer's", and does not listen or remember. FM-B stated the family was contemplating R2 being moved to a room closer to the nurses station and wondered if an alarm would assist staff when she tried to self-transfer. R2 would always self-transfer because she did not remember she could not do things independently. During an interview on 8/26/26 at 9:19 a.m., R2 was in the recliner. R2 stated she had been married for 35 years but her and her husband had been together for 17 years. When questioned about her fall on			20830			09/10/2026

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20830	Continued from page 8 8/5/26, R2 stated her husband had fallen while attempting to get out of bed and she went to help him “I’m as stable as nobody” and also fell. “Thank goodness my daughter came”. R2 then stated “well, actually, we were trying to get to each other’s room that’s why I came down and fell over and then [FM-A] came and we got it all put together”. R2 stated “I can transfer myself. I hope that will last a while”. R2 stated “they” wanted her to have someone with when she went to the bathroom. R2 picked up her call light from the overbed table next to her “I got a little clock here that works, I push it to the right number and they come. They are very good about that”. During a follow-up interview on 8/26/26 at 1:45 p.m., NA-B stated NA’s reported R2’s self-transfers to the nurse whenever she would self-transfer but the NA’s did not have anywhere in the chart they would document it. During an interview on 8/26/26 at 1:50 p.m., NA-C stated she would write down all the times R2 self-transferred on the shift she worked and give the paper to the nurse at the end of the shift. NA-C was unaware what the nurse would do with the information after she provided it. During an interview on 8/26/26 at 12:09 p.m., licensed practical nurse (LPN)-A stated R2 self-transferred 2-3 times per day on the day shift and the self-transfers occurred more when R2 was out of bed than when she was in bed. LPN-A stated the NA’s would be able to give a better answer on how often R2 self-transferred. During a follow-up interview on 8/26/26 at 1:40 p.m., LPN-A stated NA’s are educated to tell the nurse on duty if R2 was self-transferring and nurses were supposed to make a progress note about it. LPN-A stated NA’s could meet R2’s needs and she could fall two minutes later. When LPN listened to night shift report they state that a lot of the times R2 would say she was fine when they checked on her and when they go back to the room she had self-transferred to the bathroom. When questioned if R2’s self-transfers were documented in the nurses progress notes, LPN stated “Oh, God, no, probably not”. During an interview on 8/25/26 at 11:15 a.m., director of nursing (DON) stated during facility review of incident, falls were reviewed from 8/2025-8/2026, to ensure all information was accurate. Education had been provided to all staff and the specific NA involved.			20830			09/10/2026

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20830	Continued from page 9 During an interview on 8/26/26 at 2:07 p.m., DON and regional nurse consultant (RNC)-A stated the facility did not have an assessment for self-transfers. R2's fall in February was from self-transferring. Keeping the wheelchair next to wherever she is at was to help make her environment as safe as possible. R2 was not to be left alone in the bathroom. Night shift provided every two-hour rounding, and during the day and evening shift, staff would go in the room frequently to check on R2's husband and would check on R2 at the same time, however, R2's husband had recently passed away. DON conceded there was no intervention for supervision to prevent self-transfer of R2, and self-transfers were an issue that was not specifically addressed to decrease the risk of falls for R2. The facility Integrated Fall Management policy dated 9/2023, identified the purpose of the policy was to complete: fall risk assessment, identification and implementation of appropriate interventions as necessary, to maintain resident safety, prevent falls and reduce further injury from falls. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents, and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20830			09/10/2026