STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Living Community Mother of Mercy	230 Church Avenue, Box 676 Albany, MN 56307

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to develop the care plan for 1 of 3 residents (R3) reviewed for care plans when R3's care sheet directed staff to transfer with a full body mechanical lift, but the staff transferred her with a mechanical standing lift.Findings include: During an observation on 6/3/26, at 3:40 p.m., nursing assistant (NA)-B and NA-C transferred R3 from her electric wheelchair to the tub chair using a mechanical standing lift. R3's care plan, dated 4/24/26, directed transfer status as assist of two, using a full body mechanical lift and large sling. R3's annual minimum data set (MDS), dated [DATE], indicated she had diagnoses of heart failure, critical illness polyneuropathy (debilitating complication of severe systemic disease in the intensive care unit) and muscle weakness. The care sheet for R3, dated 5/21/26, directed assistance of two with a full body mechanical lift and large sling. During an interview on 6/3/26, at 3:27 p.m., R3 stated the staff transferred her with a full body mechanical lift each morning and used the mechanical stand assist lift throughout the day. During an interview on 6/3/26, at 4:14 p.m., licensed practical nurse (LPN)-B stated care provided must follow the care plan. She stated R3 should always be transferred with the full body mechanical lift. During an interview on 6/3/26, at 4:19 p.m., NA-B stated the care sheets indicated care required for each resident. She stated the sheet directed to use a full body mechanical lift, but she was a stand assist lift as well. She stated it was important to know the care required for the residents' safety. During an interview on 6/3/26, at 4:26 p.m., NA-C stated the care sheets provided the information needed to care for each resident. The sheet says full body mechanical lift but that's not actually what it is. She started R3 transferred with the full body mechanical lift in the morning, and the stand assist lift the rest of the day. She stated the care sheets should be followed for people so they don't get hurt and they get the care they need. During an interview on 6/3/26, at 4:32 p.m., nurse manager (NM)-A stated care is directed through care sheets and R3 required assistance of two staff and a full body mechanical lift for all transfers at all times. During an interview on 6/3/26, at 4:48 p.m., the director of nursing (DON) stated the NA's should use the care sheets as they reflect the care plan and R3 should have been transferred with the full body mechanical lift at all times. During an interview on 6/4/26, at 8:50 a.m., the DON stated there was a recent change in record systems and it appeared there was a transcription error on the care sheets. The facility policy Comprehensive Assessment and Care Planning policy, dated 2017, directed all person-centered care plan interventions will be implemented by qualified personnel. Interventions may be communicated through the electronic health record, resident profile, assignment sheets, and/or verbal communication.

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 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to implement interventions to reduce the risk of falls for 1 of 3 residents (R1) reviewed for accidents and supervision. R1's care plan directed bed mobility with assistance of two staff. On 5/4/26, R1 fell out of her bed while one staff provided cares without assistance. This resulted in R1's left hip fracture, pain, and fear. The immediate jeopardy (IJ) began on 5/4/26 when nursing assistant (NA)-A provided cares, including bed mobility, without the assistance of another staff person. R1's care plan, dated 4/28/26, directed assistance of two staff for bed mobility. The IJ was removed on 5/5/26 when the facility provided education to staff regarding following care plans, audits to monitor staff performance and policy review. The administrator, director of nursing (DON) and regional nurse were notified of the IJ on 6/4/26 at 1:10 p.m. The immediate jeopardy was corrected on 5/5/26 and the deficient practice corrected on 5/15/26 prior to the start of the survey and was therefore Past Noncompliance.Findings Include: R1's quarterly minimum data set (MDS), dated [DATE], indicated R1 had diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) due to cerebrovascular disease (condition affecting blood flow)affecting her non-dominant left side, cerebral infarction (stroke), anxiety and depression. She was dependent on staff for rolling side to side in bed. R1's care plan, dated 4/28/26, directed assistance from two staff for bed mobility. The care sheet, dated 5/4/26, directed assistance from two staff for bed mobility. A progress note, dated 5/4/26, indicated R1 had a fall at 7:45 p.m. when she was rolled to her side and fell out of bed. A progress note, dated 5/5/26, indicated R1 had a lot of pain related to her fall the prior evening and was receiving Tylenol for pain. A progress note, dated 5/6/26, indicated R1 was refusing to get out of bed due to severe pain rated 10/10. A progress note, dated 5/7/26, indicated R1 was sent to the hospital and had a left hip fracture. She did not have surgical repair and returned to the facility. R1 was prescribed Tramadol (an opioid pain medication) and Tylenol for pain. A hospital note dated 5/7/26, indicated R1 had a fall from bed and was diagnosed with a fracture of the left hip. An x-ray result, dated 5/7/26, indicated R1 had an acute sub capital femoral neck fracture (hip fracture where the break occurs at the junction below the femoral head and main neck of the thigh bone). A progress note, dated 5/7/26, indicated R1 returned to the facility with a diagnosis of left hip fracture. A progress note, dated 5/8/26, indicated R1's physician wrote an order for Tramadol for pain. A progress note, dated 5/8/26, indicated R1 remained in bed and rated pain of 5 -6/10. A progress note, dated 5/9/26, indicated R1 still had a lot of pain. A progress note, dated 5/11/25, indicated R1 reported pain 6-7/10 and remained in bed. A progress note, dated 5/13/26, indicated R1 complained of pain 5-7/10 and remained in bed. A progress note, dated 5/14/26, indicated R1 continued to report pain to left hip of 6-7/10 and stayed in bed. A provider note dated 5/27/26, indicated R1 had persistent left hip pain, worse with movement/rolling, at times severe. Tylenol provided minimal relief. During an interview on 6/3/26, at 12:30 p.m., R1 stated there was supposed to be two staff to provide her cares in bed. She stated NA-A assisted her to her right side; she fell between the bed and the wall, hitting the radiator, and landed on her belly. She was in a lot of pain and it was very, very traumatic. Since the incident she felt afraid during cares. She went to the hospital for an x-ray and learned her left hip was fractured. During an observation on 6/3/26, at 12:46 p.m., two staff transferred R1 from the commode to her bed via full body mechanical lift. R1 was observed to reach toward her left hip, wince, and say ouch. During an interview on 6/3/26, at 2:47 p.m., licensed practical nurse (LPN)-A stated R1 should have two staff to assist with all bed mobility. She stated she was not aware NA-A needed assistance on 5/4/26 until after the fall occurred. During an interview on 6/3/26, at 3:05 p.m., NA-A stated she was aware R1 required two staff for bed mobility but she proceeded without the assistance of another staff on 5/4/26 with R1 due to staff being (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	occupied at the time and R1 becoming frustrated due to waiting. She stated she assisted R1 to roll onto her right side. R1's left leg went over too far and R1 fell to the floor from her bed, landing face down on the floor. She stated this could have been prevented. During an interview on 6/4/26, at 8:50 a.m., the director of nursing (DON) stated R1's bed mobility should have been performed as assist of two, as the care sheet directed and R1's fall from bed was preventable. During an interview on 6/4/26, at 9:04 a.m., the primary care physician (PCP) for R1 stated R1 has been less mobile than prior to her fall on 5/4/26. He stated pain was managed with Tylenol and Tramadol. The fall was likely preventable since the staff member was not following the care plan at the time of the incident. The past noncompliance immediate jeopardy began on 5/4/26. The immediate jeopardy was removed on 5/5/26 and the deficient practice corrected by 5/15/26 after the facility implemented a systemic plan that included the following actions:-Re-educated all staff on assistance with activities of daily living (ADL) and following care plans.-Reviewed the ADL policy and the fall policy.-Tested the staff to ensure understanding of the re-education.-The Quality Assessment Performance Improvement (QAPI) committee met and reviewed the incident on 5/27/26.-Reviewed and evaluated resident care plans for interventions to reduce the risk of falls.