STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245426	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER Benedictine Living Community Owatonna		STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30th Street NW Owatonna, MN 55060	

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to timely implement physician's order to administer an anti-nausea medication and timely follow an order for transfer to emergency department for 1 of 3 residents (R1) which resulted in delay of treatment reviewed for change of condition. Findings includeFindings include:R1's face sheet dated 3/25/26, identified diagnoses of perforation of intestine (non-traumatic) (hole or tear develops in the intestine), and colostomy status (surgical opening in colon that allows stool to exit through stoma).R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had no cognitive issues. R1 had no behaviors. R1 used a walker and wheelchair for mobility. R1 required one staff assistance with dressing, transfers, repositioning, toileting, and walking. R1 had an ostomy.During a phone interview on 3/25/26 at 8:37 a.m., nursing assistant (NA)-B stated on 2/27/26, around 4:00 p.m.-4:30 p.m. she emptied R1's colostomy bag. Afterward, she walked R1 out to dinner. Five to ten minutes later, R1 stated he was not feeling well and wanted to go back to his room. NA-B walked R1 back to his room. R1 stated his stomach hurt, he was not hungry, and he wanted to lay down but went to his recliner.R1's vital signs at 6:43 p.m. BP 171/95, 02 94%, P 90, T 96.7 at 6:55 p.m. R 18, pain 3/10.R1's clinician note dated 2/27/26, identified R1 had developed nausea that afternoon and chose not to eat supper. Nursing staff noted BP was high but had been taken after an episode of dry heaving. R1 did not complain of pain. Vital signs BP 171/95, 02 94% on room air, P 90, T 96.7 R 18. R1 was in bed, awake, and alert. R1 had a colostomy mid abdomen with a small amount of stool and air in bag. Bowel sounds are present. There is diffuse mild tenderness. R1 had nausea over the past couple of hours with no abdominal pain. Zofran is available. Nursing to update MD-A later this evening.R1's signed physician order dated 2/27/26, and written on facility Physician Orders, identified R1's name, Ondansetron (Zofran) 4 mg by mouth every 6 hours as needed for nausea. The order also had handwritten called and spoke to [pharmacy] 9:24 p.m.R1's medication administration record (MAR) for 2/27/26, identified Zofran 4mg administered at 9:40 p.m. for nausea/vomiting; upset stomach comment: 9:15 p.m. Results indicated not effective.During an interview on 3/26/26 at 12:40 p.m., medical doctor (MD)-A clarified that the order for Zofran was written between 6:00 p.m.-7:00 p.m. on 2/27/26. MD-A expected Zofran would have been administered at that time as R1 had acute issues that required addressing immediately and not leisurely.During a phone interview on 3/25/26 at 8:33 a.m., NA-A stated on 2/27/26, she first had contact with R1 around 7:00 p.m. registered nurse (RN)-A had just walked out of R1's room. R1's stomach was a little bigger, but NA-A was unsure if it was from gas or something like that. R1 did not complain of pain in the area when she looked at the colostomy area. Around 9:00 p.m., RN-A requested NA-A to get vital signs on R1 because he wanted to go to the emergency department (ED). NA-A went to R1's room. R1 was in bed, head elevated, and oxygen on 1 liter per minute (LPM). R1 appeared gray in color he didn't look the greatest. R1 had a basin he was spitting phlegm into. NA-A asked R1 if he had pain and R1 pointed to his sternum area. R1 looked sweaty and was anxious. NA-A told RN-A that R1 did not look good, and his vital signs are not normal. RN-A called the doctor after NA-A gave her R1's vital signs. R1 put on his call light multiple times between 9:00 p.m.-10:00 p.m. and asked to go to the ED. NA-A did not know why RN-A did not call the paramedics.R1's progress note dated 2/27/26 (continued on next page)

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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NAME OF PROVIDER OR SUPPLIER Benedictine Living Community Owatonna		STREET ADDRESS, CITY, STATE, ZIP CODE 2255 30th Street NW Owatonna, MN 55060	

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 9:53 p.m., identified R1 refused to come out for supper, rested in recliner in room complained of stomachache. R1 refused supper when tray offered. R1 hollered for nurse to come in because his colostomy bag was going to burst open, noted to be almost empty, no need for emptying. R1 completed HS (hour of sleep) cares and transferred into bed after taking night medications orally. R1 tolerated sips of water. R1 complained of pain in epigastric (upper abdominal) region, noted to dry heave and spitting clear phlegm. R1 given Zofran 4 milligrams (mg) at 9:15 p.m. with no relief noted. R1 stated he would like to go by ambulance to the emergency room. An edit to the progress note was completed on 2/27/26 at 10:03 included: medical doctor (MD)-A was at facility to see R1 and gave order for Zofran every 6 hours as needed for nausea, and call placed to MD-A to inform of R1 not getting any better and current vitals despite having Zofran that was ordered. An edit to the progress note was completed again on 2/27/26 at 10:22 p.m. which included MD-A stated to send R1 to emergency room for increased belly pain.R1's progress note dated 2/27/26 at 10:37 p.m., identified R1's power of attorney (POA) was notified of R1 being sent to the emergency department (ED). R1 stated he had chest pain to nursing assistant (NA)-A and nothing made him feel better. R1 was pale, no emesis noted, vital signs taken with blood pressure elevated.R1's MAR for 2/28/26, identified a routine standing order for Mylanta 2-4 teaspoons. Time given was 12:17 a.m. with reason nausea/vomit; upset stomach comment: gave at 10:50 p.m. (2/27/26)R1's progress note dated 2/27/26 at 11:43 p.m., identified R1 continued to complain of sharp epigastric pain that was 10/10 [edited to note at 12:14 a.m.]. R1 was dry heaving, received antacid with no relief from pain. R1 continued to have elevated blood pressure at 146/93, which had gone down from earlier reading on evening shift. R1 had an audible expiratory wheeze and oxygen saturation ranging from 87-90% on 1 liter per minute of oxygen, oxygen was increased to 2 liters and oxygen saturations increased to 94%. R1 was pale and diaphoretic (sweaty). R1 was asked if he still wanted to go to the ED and he stated yes. Non-emergency dispatch was called for transport to ED. ED notified of R1's transfer to them.R1's progress note dated 2/27/26 at 12:13 a.m., identified R1 left with paramedics at 12:05 a.m.During a phone interview on 3/25/26 at 11:18 a.m., NA-C stated on 2/27/26, R1 was in his recliner and she assisted R1 to bed by walking to the bed. R1 stated he did not feel well and mentioned that he felt like throwing up. NA-C raised the head of the bed, put on oxygen, and gave R1 a basin in case he did throw up. NA-C reported that to RN-A. R1 called between 9:00 p.m.-10:00 p.m. and requested to go to the ED. NA-C notified RN-A.During a phone interview on 3/25/26 at 11:40 a.m., registered nurse (RN)-A stated on 2/27/26, R1 refused to come out for supper. This was unusual for R1 but happened occasionally. RN-A thought MD-A may have seen R1 after suppertime. RN-A did not communicate to MD-A until after MD-A had already seen R1 about him feeling nauseous, having high blood pressure, and refusing to eat supper. MD-A gave RN-A her phone number to call if R1 needed to be sent to ED. MD-A wrote an order for as needed Zofran. Around 7:00 p.m., R1's stomach pain moved from the ostomy site to epigastric pain. RN-A did not administer the Zofran. RN-A thought the pain could be associated with indigestion. RN-A stated only R1's BP stood out to her when she took vital signs at 6:43 p.m. and associated that with R1 not feeling well. R1 had stated he wanted to go to the ED between 9:30 p.m.-10:00 p.m. in addition to 2-3 different reports from NA's R1 wanted to go to the hospital. RN-A had other paperwork she was trying to finish up and get done with documentation during that time. RN-A could not articulate why she did not call the paramedics but guessed she was waiting to see if anything else was going to show, exactly what am I going to tell the ED for a nurse to nurse report? During shift change report licensed practical nurse (LPN)-B and RN-A decided to give R1 Maalox. RN-A stated she had edited her progress note at 9:53 p.m. to add information from MD-A and clarify the timeline of events.During a phone interview on 3/26/26 at 7:03 a.m., LPN-B stated she came to work on 2/27/26 at 10:00 p.m. for the overnight shift. RN-A reported R1 would need to be sent to the ED because R1 was sick to his stomach, dry heaving and basically vomiting up saliva. RN-A had stated he had pain on the top of his stomach at the xyphoid process (breastbone) and thought R1 could also be having a heart attack. LPN-B assessed R1 while he was in bed with the head of the bed (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Living Community Owatonna	2255 30th Street NW Owatonna, MN 55060

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	raised and he was really nauseous. LPN-B noted that he had a lot of gas in his colostomy bag. LPN-B and NA changed R1's gown prior to paramedics arriving as it had a rancid smell to it. LPN-B called the non-emergency number for the ambulance and the paramedics came to the facility within 10-15 minutes after she called. LPN-B was unaware that R1 had pain until the paramedics came. LPN-B edited her progress note to add that R1 had pain 10/10.During a phone interview on 3/25/26 at 10:16 a.m., MD-A stated she examined R1 towards the end of her day on 2/27/26 but could not recall the specific time. R1 had not been feeling well, had not eaten, and had some nausea. MD-A was aware of R1's elevated BP reading but that the reading had been obtained after R1 had an episode of dry heaving. MD-A advised RN-A to notify her later in the evening on R1's status. At that time, MD-A had not thought R1's condition was acute enough to send to the emergency department but deserved continual monitoring and rechecking of VS as a resident would not typically be sent to the hospital because of an upset stomach. MD-A's expectation was that an ambulance should be called right away immediately after the order to go to the emergency room was given.During an interview on 3/25/26 at 12:59 p.m., Administrator and DON were present. DON stated with the VS taken at 6:43 p.m., she would have expected a focused abdominal assessment completed, especially after noting there was no bowel movement in the colostomy bag and MD notification with results of the assessment. From VS taken at 9:10 p.m., RN-A should again assess R1, update MD if that had not occurred, update family, and begin transfer to emergency room process. The ambulance should have been called when the order was obtained. At 10:17 p.m., DON would have expected the ambulance to be enroute to the facility and a nurse to stay with R1 until transport complete.An email dated 3/26/26 at 12:01 p.m., identified the facility did not have a policy regarding if an ambulance required lights and sirens but the determination was made by the ambulance company when it was triaged. The facility does not have a policy on administering newly ordered medications for a change of condition.The facility Change in Condition, Resident Examination and Evaluation dated 11/10/25, identified a thorough resident examination and evaluation will capture any abnormalities in health status, physical function, or an acute change of condition. When a significant change in the residents physical, mental, or psychosocial status is identified by licensed nurse, the license nurse consults with attending provider and notified the resident/resident representative. Obtain VS and repeat as needed or ordered. Notify the provider of change in condition and implement orders for treatment and appropriate monitoring as directed. Notify the resident/resident representative. Document symptom(s), assessment, observations, resident/resident representative, and medical provider notification. Monitor and provide treatment as ordered by the attending provider.