STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Living Community Owatonna	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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interview and document review, the facility failed to develop a baseline care plan to ensure immediate care needs for surgical incision care and his urinary incontinence were addressed for 1 of 3 residents (R2) reviewed. R2's progress note, dated 4/13/26, identified R2 admitted to the care center and had several medical conditions including peripheral arterial disease (PAD), acute kidney injury, chronic kidney disease (CKD), and high blood pressure. R2 needed assistance for all activities of daily living (ADLs), needed cues and reminders to ask for help, and was alert and oriented to self. The note identified R2 had been incontinent of urine and was unaware of such. Further, the note included a section labeled Skin that identified, . two healing surgical sites in bilateral groin . Bruising to BUE [bilateral upper extremities] . Small scabbed area to posterior calf on LLE [left lower extremity . All areas OTA [open to air] and not draining. No redness, swelling, or warmth to peri-wounds. R2's Care Plan, dated 4/22/26, identified all the potential or actual problems R2 had, along with goals and interventions to address them. This identified a section labeled Category: Bowel & Bladder Function that recorded R2 as having bladder and bowel incontinence along with interventions to address it, which included keeping the call light within reach, monitoring for signs of infection, providing R2 with the urinal/bedpan/commode as needed, and offering him toileting frequently. However, this section of the care plan and its interventions were initiated on 4/20/26 (seven days after admission). The care plan continued and listed a section labeled Category: Pressure Ulcer/Injury that recorded R2 as admitting with multiple surgical incisions and being at risk of skin breakdown. The plan listed several interventions including monitoring the skin, being involved in the treatment process, and applying barrier creams if needed. However, again, this section and its interventions were initiated on 4/20/26 (seven days after admission). R2's medical record lacked evidence that a comprehensive baseline care plan had been developed within 48 hours of admission to address these areas of R2's care despite him having active surgical wounds and being incontinent of urine upon admission as recorded in the progress notes. When interviewed on 5/12/26 at 1:24 p.m., nursing assistant (NA)-A stated they recalled working with R2. NA-A explained R2 needed help to use the bathroom and would, at times, refuse basic cares like getting cleaned up. NA-A stated they recalled trying to reposition R2 every few hours and were unsure if he ever had skin issues or wounds adding, I don't remember that. When interviewed on 5/12/26 at 1:27 p.m., licensed practical nurse (LPN)-C stated the facility did not use a specific baseline care plan but rather just started to build the comprehensive one upon admission. LPN-C stated care plans were made usually by the nurse managers, director of nursing (DON) and social worker team as they reviewed the evaluations the floor staff completed. LPN-C reviewed R2's care plan and verified the skin and bladder/bowel sections were initiated on 4/20/26 which was a week after R2 was admitted to the center. LPN-C stated the baseline care plan should be done within a few days after admission. LPN-C stated having a baseline care plan was important as it assisted the staff with caring for the person in the early part of their admission. On 5/13/26 at 10:33 a.m., the DON and administrator were interviewed. DON explained that the MDS (Minimum Data Set) nurses helped complete the care plan by reviewing the floor staff observations and evaluations which included a toileting plan, if needed. DON verified there was not a separate baseline care plan template (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	used and that R2's skin or bladder/bowel plans were not initiated until 4/20/26. DON stated they should have been initiated within 48 hours after admission to the care center but with weekend admission it could take a little bit longer at times. DON stated they would be doing education on this to the staff and added having a baseline care plan was important for the staff to know how to care for the resident. A provided Comprehensive Assessments and Care Planning policy, dated 2/2026, identified the assessment process of a resident begins with the development of the baseline care plan within the first 48 hours of admission. The plan should have the minimum healthcare information needed to care for them on admission including but not limited to their initial goals, physician orders, dietary orders, and social services. The policy continued, The baseline care plan reflects the resident's stated goals and objective, and includes interventions that address his or her current needs.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to educate on risk and prevention of deep vein thrombosis (DVT); failed to ensure applied compression wraps for DVT prevention were clarified upon admission for ongoing use; and failed to ensure physician orders for resumption of anticoagulant (blood thinning) medication were acted upon timely to help reduce the clotting risk for 1 of 3 residents (R1) reviewed. R1 was subsequently hospitalized and died due to severe blood clotting with an ischemic (insufficient blood flow) leg and pulmonary embolism (clot in the lung) resulting in actual harm for R1. In addition, the facility failed to ensure surgical incisions were adequately monitored by nursing staff to reduce the risk of complication (i.e., delayed response to infection) for 1 of 3 residents (R2) reviewed who had surgical wounds. Findings include: R1: R1's Hospitalist Discharge summary, dated [DATE], identified R1 would be transitioned to the care center and listed a principal problem of acute cholecystitis (gallbladder inflammation). R1's other active problems included high blood pressure, heart failure, and atrial fibrillation (irregular heart rhythm). R1 was described as a [AGE] year-old female who admitted to the hospital on [DATE] with acute cholecystitis and underwent surgery for this condition. R1 then developed atrial fibrillation with rapid ventricular rate (RVR). The summary outlined, Eliquis (anticoagulant - blood thinner) on hold postoperatively. R1 discharged the hospital with a Jackson Pratt (JP) drain (a tube placed into a wound to allow drainage of fluid) in place and would follow up in the general surgery clinic. The note added, She will hold Eliquis until JP drain is removed. R1's corresponding After Discharge Orders, dated [DATE], identified R1's hospital discharge orders. These listed a section labeled, Discharge Medications that contained two medications listed under the heading, PAUSE taking these medications. One of the medications listed under this heading was Eliquis 2.5 milligrams (mg) with directions below, Wait to take this until your doctor or other care provider tells you to start again. After JP [Jackson Pratt] drain is out. The orders included no other anticoagulant medications or directions for compression wraps to be applied. R1's progress note, dated [DATE], identified R1 admitted to the care center, and she was alert and oriented. R1 had multiple medical conditions including atrial fibrillation and she had a JP drain in place with bloody drainage present. The note recorded, No edema. Wearing compression socks. HR [heart rate] irregular. R1's vital signs were stable on one liter of oxygen (O2). Licensed practical nurse (LPN)-C authored the note. A subsequent note, dated [DATE], identified R1 was seen by physical therapy (PT) and initial evaluations were completed. The note recorded, Assist of 2 pivot transfers. Assist of 2 toileting and self-cares. R1's progress note, dated [DATE], identified R1 was seen by occupational therapy (OT) and identified, Transfers: 1A [one assist] pivot w/ 4WW [walker] . Self Cares: Extensive assist . Toileting: 1A pivot w/ grab bars. R1's Progress Note, dated [DATE], identified R1 was seen by the general surgery service for post-operative follow-up. The note identified the surgery was on [DATE], and the patient was doing well and the JP drain had not had output for a few days. The JP drain was removed, and the site was reapproximated with Steri-Strips. The note recorded, [R1] is doing well postoperatively . At this point the patient is dismissed from our surgical service. The note identified sections below the dictation which read, Orders Placed, and Medication Changes, but these were both answered with text reading, None. The note did not address R1's Eliquis, which remained on hold since she was admitted to the care center six days prior.R1's admission Minimum Data Set (MDS), dated [DATE], identified R1 had intact cognition along with several medical conditions including heart failure and atrial fibrillation. The MDS identified R1's consumed medications during the evaluation period, where the space to record anticoagulant consumption was left un-checked (i.e., not administered). R1's progress note, dated [DATE], identified R1 was seen by therapy and was now an assist of one for walking to and from the bathroom with a gait belt and walker. The note identified, [R1] is to walk 3x day with a [walker] and 1 A with gait belt and [wheelchair] follow. R1's H&P (History & Physical), (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	dated [DATE], identified R1 was seen by the medical doctor (MD)-A for a routine nursing home visit due to admission. R1 had been recently hospitalized for sepsis (life-threatening response to infection) due to acute cholecystitis and had surgery. R1 developed atrial fibrillation with RVR post-operatively and was discharged to the care center on [DATE] with a JP drain in place. The note recorded, Since discharge she feels generally well and has no nausea. She has significant fatigue . she notes an irregular heartbeat. MD-A completed a physical examination of R1 which outlined, Extremities: Normal without edema. The note listed a section labeled, ASSESSMENT/PLAN that reviewed each medical condition and subsequent orders for them. This included, Atrial Fibrillation Paroxysmal (HCC), and dictation that read, Persistent with mildly elevated ventricular rate after recent sepsis hospitalization . Apixaban [Eliquis] was to be restarted when JP drain was removed. I wrote that order today. R1's subsequent order, dated [DATE], identified directions which included taking Eliquis 2.5 mg orally twice a day. The order was signed by MD-A on [DATE] (four days after the JP drain was removed) at 9:31 p.m., and the fax was time-stamped it was received by the care center at 9:33 p.m. R1's Medication Administration Record (MAR), dated 4/2026, identified R1's administered medications for the month period. This included an order for Eliquis 2.5 mg twice a day with dates recorded, [DATE] - [DATE]. The medication was recorded as not being administered on [DATE] for either dose with comments written, Other . pharmacy will deliver med ASAP, and Drug/Item unavailable. R1's first recorded dose of the Eliquis was on [DATE] (two days after being ordered) in the morning hours. The medication was provided until [DATE] (evening) and the space to record the morning dose on [DATE] was left blank with nothing identified. Further, R1's Treatment Administration Record (TAR) lacked any evidence of use of compression wraps or TEDs despite R1 admitting from the hospital with them on. R1's medical record lacked evidence R1 had been educated on DVT prevention including potential exercises R1 could do on her own while in bed to help prevent blood clots (i.e., ankle pumps); it lacked evidence R1's compression wraps, which were present on her upon admission, were clarified with the provider to determine if these should continue given R1 being off her anticoagulant medication and being at increased risk of blood clot; and lacked evidence of any shift-to-shift nursing monitoring (i.e., calf measurements, leg pain, skin discolorations) for a potential blood clot despite R1 being off her anticoagulant medication. Further, the record lacked evidence that the care center had acted upon the hospital's discharge order and notified the physician to resume the Eliquis when the JP drain was removed prior to [DATE], despite the drain being removed on [DATE] (four days earlier). R1's progress note, dated [DATE], identified the nursing assistant (NA) reported R1 sat on her bedside and was unable to move her left leg. The note recorded the leg, . appeared to be difference [sic] in color and cooler than right side . resident said that she couldn't feel sensation on left foot. Called for ambulance and called daughter . left via ambulance R1's Emergency Department (ED) Encounter, dated [DATE], identified R1 presented with decreased sensation in her left leg with the leg being, cool and dusky with a visible color change. Unable to Doppler pulses extending up to the popliteal. [back of the knee] The note identified a CT was completed which identified an acute pulmonary embolism [blood clot in the lung] and near complete occlusion of the entire left iliofemoral and femoropopliteal system. The note identified when R1 arrived at the acute care hospital ED, she was having pain in her left hip that was, . still severe at 10/10. R1 was given heparin (an anticoagulant) via IV in the ED and the note identified, She is being treated with heparin and will be sent to the OR emergently with vascular surgery for femoral cutdown, thrombectomy, [removal of blood clots], and likely fasciotomies [removal of facia] given the degree of ischemia. [death of tissue]. Both Dr. [name] from vascular surgery and I did impress upon the patient and her family the gravity of the situation and that she may well die in surgery but would almost certainly die without it. R1 agreed to the operation. On [DATE] at 1:21 p.m., R1's family member (FM)-A was interviewed. They explained that R1 was admitted to the care center following a hospitalization for gallbladder surgery and was not considered to be in terminal condition during the hospitalization or while admitted to the care center. R1 planned to return home to their assisted living facility (ALF) when (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	they completed rehabilitation therapy at the care center. FM-A explained R1 had been on Eliquis prior to the hospitalization but it was held for her surgery and R1 discharged from the hospital to the nursing home with orders to resume the medication from their understanding. However, some issue happened that caused R1 to go for almost two weeks without the medication. FM-A stated their other family member had learned the medication was re-started on [DATE], when they started asking staff some questions about the medication. Then on [DATE], R1 developed a blood clot and had to be taken to the hospital where a significant clot was found. FM-A stated R1 must have been off the medication a fatal amount of time as the clot, which happened on [DATE], caused R1 to be hospitalized and R1 then passed away while in the hospital. FM-A stated watching R1 having pain and ultimately dying in the hospital was a very sad thing to experience and reiterated R1 planned to return to their ALF after the care center, until this medication incident happened. When interviewed on [DATE] at 10:17 a.m., nursing assistant (NA)-A stated they recalled working with R1 who needed minimal assistance with most cares. NA-A stated they could not recall R1 using compression wraps or TEDs while at the care center adding, I'm not sure on that. NA-A stated R1 ambulated using a walker but not when she first admitted to the care center, adding the ambulation was more at the end before she was hospitalized . NA-A stated they heard R1 had developed a blood clot and had to be hospitalized but was unsure of the details around it. When interviewed on [DATE] at 10:24 a.m., licensed practical nurse (LPN)-C reviewed R1's medical record and explained she was admitted to the care center following gallbladder surgery with a JP drain in place. LPN-C stated compression wraps or TEDs would need a physician order for use and R1 didn't have them ordered upon admission. LPN-C reviewed the progress note they authored (dated [DATE]), which identified R1 had them physically on when she admitted , and verified the record lacked evidence using them had been clarified with the physician. LPN-C adding that it should be a group of people who could have acted on that. LPN-C stated they did not recall R1 using compression wraps or TEDs while at the care center after she admitted and stated, It was not followed up on. LPN-C stated monitoring for a potential blood clot would likely be charted in the Medicare charting progress notes, however, R1's note template did not have that listed as something to monitor. LPN-C stated if a medication, like Eliquis, was on hold from the hospital then the floor staff wouldn't always know that information, adding unless the person was here for a hip fracture or something of that nature, then staff would likely not be alert to a potential clot risk like R1 had. When questioned about who was responsible for assigning or developing the shift-to-shift monitoring notes, LPN-C stated the health unit coordinator (HUC) used to read the hospital notes and help suggest or implement some monitoring, but the position had been patching together for several weeks due to leaves and resignations. LPN-C then reviewed R1's Eliquis and stated the order to resume it was faxed to the center on [DATE] late in the evening and entered in the EMR to begin on [DATE]. LPN-C acknowledged the doses on [DATE] were not administered and said they were unsure why it wasn't given, as a supply of Eliquis was available in the onsite emergency kit (E-kit). LPN-C stated they were unsure why there had been a delay of multiple days after the JP drain was removed, to when the Eliquis was restarted. LPN-C stated it was likely missed as the order to resume it had not been entered into the EMR for staff to ask about it: We [floor staff] may never have known her Eliquis was on hold if we didn't look at the actual hospital summary. LPN-C stated not entering the orders on hold upon admission caused things to be left to chance sometimes. LPN-C stated they felt all orders, including medications on hold, should be entered into the EMR so the floor staff were aware of them, adding, The more information we have, the better. Further, LPN-C stated Eliquis was considered a high-risk medication and not getting the medication resumed for multiple days which caused missed doses, would be a concern, adding aloud, It's significant. When interviewed on [DATE] at 11:23 a.m., registered nurse (RN)-A explained that when someone admitted from the hospital the HUC would take the information and enter it into the EMR. Then nurse would then verify it: If I have time. RN-A stated if someone admitted with an order to hold Eliquis until a drain was removed, then they would place a general note in the EMR such as an (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	FYI-type thing. RN-A stated the need to resume it should be posted somewhere in the EMR for the floor staff to see repeatedly otherwise the order was likely to be missed. RN-A stated entering the order was not necessarily the policy of the campus but rather something I would do. RN-A stated if someone admitted to the care center with compression wraps on but no order for them, it should be clarified right away. RN-A stated the shift-to-shift monitoring for each resident was determined by either the HUC or the floor nurse and entered into the system using the progress notes. RN-A stated they personally tried to review hospital notes on the residents, but not every nurse does that, adding some newer nurses seem to be very focused on the orders only and not looking at the whole situation of the resident. On [DATE] at 1:59 p.m., unit nurse manager (RN)-B, the director of nursing (DON), and administrator were interviewed. DON stated someone using an anticoagulant medication would more likely be monitored for bleeding risk and they would typically need at least a provider recommendation to monitor for clots before that would be entered and tracked in the EMR. DON reiterated none of the hospital discharge paperwork or subsequent physician notes directed to monitor for potential blood clots. However, DON stated if nursing had concerns about it then they could initiate a nursing order and update the medical provider. RN-B stated there was no order for compression wraps from the hospital when R1 admitted and felt maybe they were not needed anymore, adding it was hard for me to say if someone ever clarified it or not with the provider. DON stated if there were questions about the wraps being used or not, then someone could have reached out to the provider and clarified it. RN-B and DON also verified they were unable to locate any documentation to show R1 had been educated on the risk of blood clots and steps to reduce them. DON then reviewed R1's Eliquis and explained it wasn't an active order when she admitted on [DATE] so it would not have been entered into the EMR as it could cause a medication error. DON stated in R1's scenario that multiple people could have caught the order to resume it once the JP drain was removed including the medical provider who physically removed the drain itself, but they never addressed it in their note. DON stated the person who reviewed the notes on admission would be the system to catch this and resume the medication. When asked how it would be handled if that person was not working or resigned in the meantime, the DON replied, I don't know if we have a fool-proof system in place for that, and suggested maybe using a sticky note on the desk in the office. DON verified there was no system outside of the EMR in place to ensure orders like R1's were identified and acted upon timely. DON explained the pharmacy sends medications to the campus once a day usually in the early morning hours, so an order received late at night wouldn't likely arrive the following day, however, the E-Kit was available and had some of that medication inside at the time on [DATE] to at least provide a dose. DON stated they would consider Eliquis to be a high-risk medication, and it should be given timely when ordered to help prevent blood clots. The DON and RN-B both acknowledged room to improve the communication surrounding this incident with R1 and the administrator expressed they felt the medical provider should have a responsibility to review medications after surgery adding they were unsure why the provider on [DATE] didn't address the medication then. When interviewed on [DATE] at 2:32 p.m., MD-A stated they were the campus' medical director and verified they had physically seen R1on [DATE] for the visit. MD-A stated they did not recall if anyone from the care center had clarified the compression wraps with them or not and expressed an order for their use was typically needed. MD-A stated either them or the nurses could catch that and have clarified it when R1 was admitted . MD-A stated use of compression wraps or TEDs was an intervention to help prevent blood clots in the legs and clarifying the order for R1 on [DATE] would have [been] a reasonable thing to do. MD-A stated they did not recall providing any education to R1 on the prevention of blood clots, either. MD-A reviewed R1's Eliquis and stated they learned it was to be restarted on [DATE] when the visit happened but were unsure if they identified that themselves or if the nurses at the center raised the issue with them. MD-A stated when they saw R1 on [DATE], there was no concern for a blood clot in her leg at that time, so the clotting most likely happened after that visit. MD-A stated if R1 had her Eliquis restarted immediately after the JP drain was removed (on [DATE]) it was (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	hard to say, if a clot and subsequent hospitalization could have been avoided but MD-A added, Its possible it may have changed the outcome. MD-A stated if the medication was available in the E-Kit then a dose could have been removed and provided immediately following the order on [DATE] adding, That would be a med I would administer sooner rather than later. MD-A stated it was hard to say if they expected to be notified by the nurses on [DATE] when the JP drain was removed but added that given the situation with R1 and what happened with her developing a clot it would have been a great loop closure to have been notified. MD-A expressed, The takeaway [from this] is to identify loops that need to be closed and figure out the best process for doing that. MD-A stated, in hindsight, the nurses could have notified their service about the Eliquis adding, That would have been nice, but it didn't happen. On [DATE] at 3:23 p.m., the dispensing pharmacist (DP)-A was interviewed and verified their service distributed the medications to the campus. DP-A stated their current formulary showed Eliquis as being available in the campus E-Kit, but they would have to check and then send a review of the retrospective inventory after the interview to confirm a medication supply was available on [DATE]. DP-A stated nurses were always able to call them and ask about medication supply if they had questions about it. DP-A stated Eliquis was a medication the patient should not be without for a long period and explained the half-life of the medication (the time it takes for the concentration of that drug in your body to reduce by exactly 50%) was about 12 hours, and the medication starts working within an hour of being given. If a patient went for several days without it, then the effects of the medication would likely be totally removed from the body systems. DP-A stated having a period of multiple days unnecessarily going without the medication would make a difference with the risk of blood clots being formed adding, It would matter something. When interviewed on [DATE] at 4:05 p.m., the director of therapy (DOT) stated they were not the primary therapist who worked with R1 while she was at the care center, however, was somewhat familiar with her care and services she received. DOT stated the therapist chart in their own system, and they had reviewed the notes for R1, which identified R1 as not very mobile when she first admitted but then was progressing really well until she discharged to the hospital. DOT verified they were unable to locate any documentation to show R1 had been educated on the risk of blood clots and subsequent prevention techniques she could do on her own such as ankle pumps. DOT also was unable to locate any information on R1's use of compression wraps while at the care center and stated the nurses were able to facilitate those if desired or needed. DOT stated they felt the education on DVT prevention was typically provided, however, there was nothing documented for R1 to show it had happened.An e-mail correspondence received from DP-A on [DATE] at 5:28 p.m., identified Eliquis was available with at least one dose in the E-Kit on [DATE]. The email identified, It appears that the facility had a balance on hand in their [kit] to initiate therapy before the cards were delivered. A provided Physician Services policy, dated 1/2019, identified the care center would provide services related to physician services in accordance with State and Federal regulations. This included a procedure which directed, All physician orders will be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record during that shift. R2:On [DATE] at 12:35 p.m., R2's family member (FM)-D was interviewed. R2 was admitted to the care center after being hospitalized for an extended period due to multiple conditions and he had used a catheter while in the hospital, but it was removed before he discharged to the care center on [DATE]. FM-D stated R2 was doing good with using the bathroom and able to sense the need to go when he left the hospital. R2 also had some healing surgical incisions near his groin which were all intact and open-to-air (OTA). However, then they opened while at the care center and R2 had to eventually go back to the hospital due to them being re-opened and becoming infected. FM-D questioned what wound cares had been provided and how these closed, healing wounds could have re-opened. R2's progress note, dated [DATE], identified R2 admitted to the care center and had several medical conditions including peripheral arterial disease (PAD), acute kidney injury, chronic kidney disease (CKD), and high blood pressure. R2 needed assistance for all activities of daily living (ADLs), needed cues and reminders to (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	ask for help, and was alert and oriented to self. The note identified R2 had been incontinent of urine and was unaware of such. Further, the note included a section labeled, Skin, which identified, . two healing surgical sites in bilateral groin . Bruising to BUE [bilateral upper extremities] . Small scabbed area to posterior calf on LLE [left lower extremity . All areas OTA [open to air] and not draining. No redness, swelling, or warmth to peri-wounds. R2's Care Plan, dated [DATE], identified all the potential or actual problems R2 had along with goals and interventions to address them. This identified a section labeled, Category: Bowel & Bladder Function, which recorded R2 as having bladder and bowel incontinence along with interventions to address it including keeping the call light within reach, monitoring for signs of infection, providing R2 with the urinal/bedpan/commode as needed, and offering him toileting frequently. The care plan continued and listed a section labeled, Category: Pressure Ulcer/Injury, which recorded R2 as admitting with multiple surgical incisions and being at risk of skin breakdown. The plan listed several interventions including monitoring the skin, being involved in the treatment process, and applying barrier creams if needed. R2's medical record, including progress notes and treatment records, lacked evidence of any ongoing or shift-to-shift monitoring of R2's healing surgical wounds from [DATE] to [DATE]. There was no evidence they were being observed by the nurses for symptoms of infection or potential dehiscence (surgical complication where a closed wound or incision ruptures and opens). In addition, R2's Wound Management section of the electronic medical record (EMR) lacked any evidence the surgical incisions were being tracked or monitored. R2's progress note, dated [DATE], identified R2 refused morning cares and his bedding was soiled. The nurse responded and assisted R2 into the bathroom and completed a body audit. The note identified, Writer observed right inguinal/groin with full thickness wound measuring 1.7 cm [centimeters] X 1.9 cm. Large nodule purple in color right inguinal/groin inferior to wound measuring 5 cm X 7 cm. The left groin incision was recorded as well approximated and R2's vital signs were stable. A subsequent note, dated [DATE], identified an SBAR (acute situation update) note was faxed to the hospital and R2's family was updated, . of concern of incisions. When interviewed on [DATE] at 1:24 p.m., nursing assistant (NA)-A stated they recalled working with R2. NA-A explained R2 needed help to use the bathroom and would, at times, refuse basic care like getting cleaned up. NA-A stated they recalled trying to reposition R2 every few hours and were unsure if he ever had skin issues or wounds adding, I don't remember that. When interviewed on [DATE] at 1:27 p.m., licensed practical nurse (LPN)-C stated if someone admitted with surgical wounds then they'd have daily monitoring done when the incision dressing was changed. If the wounds were open to air, such as R2's were, then the monitoring would be done and recorded on the Medicare charting notes in the progress notes or on the TAR. LPN-C stated there should be an order for monitoring with any surgical incision for at least daily [checks]. LPN-C reviewed R2's medical record and acknowledged it lacked evidence of any ongoing monitoring of the surgical incisions from [DATE] to [DATE]. LPN-C stated it was important to ensure incisions, even if closed and healing, were monitored until the wound was completely resolved. LPN-C stated they saw R2's incision on [DATE] when it had re-opened and completed the SBAR update to the physician. LPN-C stated they were unsure what had happened or caused it to open, but R2 ended up going to the hospital a few days later to have it addressed. On [DATE] at 10:33 a.m., the director of nursing (DON) and administrator were interviewed. DON explained a skin observation is completed upon admission and wounds or incisions should be recorded on that evaluation. If a surgical incision was present, which was draining or had concerning presentation, then the nurses could contact the medical provider or onsite wound nurse to review it. DON stated the NA staff were taught to observe the skin each day with cares and felt they'd report issues if seen. DON stated the Medicare charting is determined by the MDS nurses and not everyone would get incisional monitoring included, especially if the incisions were open to air like R2's were upon admission. DON verified they were unable to locate documentation to show any monitoring of the incisions from [DATE] to [DATE] and reiterated the NA staff were taught to check the skin with daily care. A provided Prevention and Treatment of (continued on next page)

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	245426	A. Building B. Wing	05/13/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	Skin Breakdown policy, dated 9/2018, identified resident skin was assessed upon admission and weekly thereafter. A resident who was at increased risk for breakdown would be provided preventative measures to reduce the potential risk of skin breakdown. A procedure was listed that outlined steps to be completed which included, Skin is observed daily with cares. If any skin concerns are noted, they are reported to the licensed nurse. The procedure then shifted to more pressure ulcer prevention and care and lacked any specific guidance or process for surgical incision monitoring.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to comprehensively assess and, if needed, develop a toileting program to promote urinary continence and reduce the risk of complication (i.e., skin infection, breakdown) for 1 of 3 residents (R2) reviewed. On 5/12/26 at 12:35 p.m., R2's family member (FM)-D was interviewed. R2 was admitted to the care center after being hospitalized for an extended period due to multiple conditions and he had used a catheter while in the hospital, but it was removed before he discharged to the care center on 4/13/26. FM-D stated R2 was doing good with using the bathroom and able to sense the need to go when he left the hospital. R2 also had some healing surgical incisions near his groin which were all intact and open-to-air (OTA). However, then they opened while at the care center and R2 had to eventually go back to the hospital due to them being re-opened and becoming infected. FM-D stated the family had visited at times and found R2 to be incontinent of urine which made them question if that contributed to the incisions becoming infected, adding, Nursing 101 is keep the incision sites clean and dry. FM-D stated they were unsure if R2 ever attempted or was placed on a toileting plan while in the care center to help reduce the incontinence. R2's progress note, dated 4/13/26, identified R2 admitted to the care center and had several medical conditions including peripheral arterial disease (PAD), acute kidney injury, chronic kidney disease (CKD), and high blood pressure. R2 needed assistance for all activities of daily living (ADLs), needed cues and reminders to ask for help, and was alert and oriented to self. The note identified R2 had been incontinent of urine and was unaware of such. Further, the note included a section labeled Skin that identified, . two healing surgical sites in bilateral groin . Bruising to BUE [bilateral upper extremities] . Small scabbed area to posterior calf on LLE [left lower extremity . All areas OTA [open to air] and not draining. No redness, swelling, or warmth to peri-wounds. R2's Clinical Documentation (Admission), dated 4/13/26, identified a review of system completed upon admission. This identified R2 as needing supervision to complete a toileting transfer and partial/moderate assistance with toileting hygiene. The evaluation listed a section labeled Bowel and Bladder that identified R2 used no appliances, was frequently incontinent of urine and occasionally incontinent of bowel. There was no further assessment of R2's incontinence or dictation of what, if any, toileting program was needed, considered or attempted. R2's Bladder evaluation, dated 4/17/26, identified R2 used no appliances for elimination and was recorded as being frequently incontinent of urine. R2 was unable to recognize the appropriate time or place to urinate but was able to sense the urge to void. R2 had impaired mobility and severe cognitive impairment and was currently incontinent of bladder with his clothes being found wet. The evaluation listed multiple sections to be completed which included Section 5 - Further Assessment that had space to record a physical examination, a post-void residual (PVR), and if a urinalysis was performed, along with spacing to write the results. However, this section was left entirely blank and not completed. The section labeled Section 6 - Incontinence Symptom Profile had options to select which type of incontinence R2 was assessed to have present (i.e., urge, functional), however, this section was also left blank with nothing being selected or recorded. The section labeled Section 7 - Summary of Program Placement Decision identified R2 with functional incontinence, however, the remainder of the section, including spacing to record what toileting program was needed or if was not appropriate, was left blank and not completed. The evaluation concluded with summarized findings reading, Resident incontinent of bladder. Does ask for urinal at times. Known to attempt urinal per self however not appropriately. Staff assist with incontinence cares. The evaluation was completed by licensed practical nurse (LPN)-C. R2's admission Minimum Data Set (MDS), dated [DATE], identified R2 admitted to the care center on 4/13/26 from the acute-care hospital. The MDS identified R2 had severe cognitive impairment and had surgical wounds present. Further, the MDS identified R2 used no elimination appliances (i.e., (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	catheter) and was recorded as always incontinent of bowel and bladder; however, a toileting program had not been attempted since admission. R2's corresponding Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 4/21/26, identified R2 had no modifiable risk factors identified, demonstrated urinary urgency and needed assist with toileting, and demonstrated functional incontinence (i.e., can't get to toilet timely). The CAA identified, CAA triggered due to resident is always incontinent of urine. Contributing factors include need for staff to assist with toileting. He is at risk for skin rashes, skin breakdown, and urinary infection. No referrals at this time. Will proceed to care plan to minimize risks. The CAA did not address if a toileting plan was considered, appropriate, or rationale why not to attempt one despite the incontinence and R2 being recorded as using the urinal at times. R2's Care Plan, dated 4/22/26, identified all the potential or actual problems R2 had along with goals and interventions to address them. This identified a section labeled Category: Bowel & Bladder Function that recorded R2 as having bladder and bowel incontinence along with interventions to address it including keeping the call light within reach, monitoring for signs of infection, providing R2 with the urinal/bedpan/commode as needed, and offering him toileting frequently. This section of the care plan and its interventions were initiated on 4/20/26 (seven days after admission) and the plan lacked any further dictation or description of what frequently meant for his toileting. When interviewed on 5/12/26 at 1:24 p.m., nursing assistant (NA)-A stated they recalled working with R2. NA-A explained R2 needed help to use the bathroom and would, at times, refuse basic cares like getting cleaned up. NA-A stated they tried to help R2 with toileting every few hours or when he used the call light asking for the urinal. NA-A stated R2 was able to sense when he needed to void and would off and on use the call light to alert staff. NA-A stated they did not recall if R2 was on a formal toileting program or not but reiterated R2 would tell them if he needed to use the bathroom or not adding, He usually told us. R2's medical record was reviewed and lacked evidence R2 had been comprehensively assessed for his bladder function and incontinence including to determine what, if any, toileting program may be beneficial for R2 since he was able to sense the need to void, could alert staff for assistance, and had active healing surgical wounds around his groin, which were at risk for infection. When interviewed on 5/12/26 1:27 p.m., LPN-C verified they completed the bladder evaluation for R2 (dated 4/17/26) and explained upon admission each resident has the Clinical Documentation evaluation completed and a Bladder evaluation completed after that. This should happen within the first seven (7) days after admission. LPN-C reviewed R2's completed Bladder evaluation and stated the section for a physical assessment (Section 5) was often not completed unless someone had a recent appliance removed or had pending lab results. LPN-C verified this was left blank on R2's evaluation (despite him using a catheter in the hospital for a period). The section for the incontinence profile (Section 6) was used to record the incontinence type and LPN-C verified the areas not completed and responded, You're right. LPN-C stated they could have completed that section and there was a missing aspect under that [section]. LPN-C stated the section for the toileting program determination (Section 7) was also left nearly blank and acknowledged no decision for a program adding, You're right. LPN-C stated they were unsure why they didn't complete the evaluation and program selection adding, I guess I can't answer that. LPN-C stated the center rarely used a three-day tracking diary or other tool to evaluate potential toileting programs, but the staff could check the recorded point-of-care (POC) responses if needed, but added, I personally do, but can't speak for others. On 5/13/26 at 10:33 a.m., the director of nursing (DON) and administrator were interviewed. DON explained that the Bladder evaluation is completed after a few days from admission and the MDS nurses will then develop a care plan from that information and determine if a toileting program should be implemented with therapies (PT/OT) able to give input on that decision. DON stated the center didn't do a toileting program often, rather just did basic plans like assistance before meals, after meals, and as requested. DON stated the word frequently was a very vague term on the care plan. DON explained each section of the Bladder evaluation and stated they expected the sections left all or mostly blank on R2's evaluation (i.e., 5 - 7) to be completed. This was (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	important to do as it's a requirement and helps staff to have a clearer picture of the resident. DON acknowledged the record lacked evidence or rationale why this had not been done for R2. A facility policy on bladder evaluations was requested; however, none was received.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure high-risk medications were provided timely after being ordered to help prevent potential blood clots for 1 of 1 resident (R1) reviewed. R1 had Eliquis (an anticoagulant, blood thinning, medication) ordered by the medical doctor (MD)-A on 4/10/26; however, this was not provided to R1 until 4/12/26 despite supply of the medication available in the emergency kit (E-Kit) onsite. R1's Hospitalist Discharge summary, dated [DATE], identified R1 would be transitioned to the care center and listed a principal problem, Acute cholecystitis (gallbladder inflammation). R1's other active problems included high blood pressure, heart failure, and atrial fibrillation (irregular heart rhythm). R1 was described as a [AGE] year-old female who admitted to the hospital on [DATE] with acute cholecystitis and underwent surgery for this condition. R1 then developed atrial fibrillation with rapid ventricular rate (RVR). The summary outlined, Eliquis on hold postoperatively. R1 discharged the hospital with a Jackson Pratt (JP) drain in place and would follow up in the general surgery clinic. The note added, She will hold Eliquis until JP drain is removed. R1's corresponding After Discharge Orders, dated 4/1/26, identified R1's hospital discharge orders. These listed a section labeled, Discharge Medications that contained two medications listed under the heading, PAUSE taking these medications. One of the medications listed under this heading identified the Eliquis and directions below, Wait to take this until your doctor or other care provider tells you to start again. After JP [Jackson Pratt] drain is out. The orders included no other anticoagulant medications.R1's Progress Note, dated 4/6/26, identified R1 was seen by the general surgery service for post-operative follow up. The note identified the surgery was on 3/26/26, and the patient was doing well and the JP drain had not had output for a few days. The JP drain was removed, and the site was reapproximated with Steri-Strips. The note identified sections below the dictation that read, Orders Placed, and Medication Changes, but these were both answered with text reading, None. The note did not address R1's Eliquis, which remained on hold since she was admitted to the care center six days prior.R1's H&P (History & Physical), dated 4/10/26, identified R1 was seen by the medical doctor (MD)-A for a routine nursing home visit. The note recorded, Since discharge she feels generally well and has no nausea. She has significant fatigue . she notes an irregular heartbeat. The note listed a section labeled, ASSESSMENT/PLAN, which reviewed each medical condition and subsequent orders for them. This included, Atrial Fibrillation Paroxysmal (HCC), and dictation which read, Persistent with mildly elevated ventricular rate after recent sepsis hospitalization . Apixaban [Eliquis] was to be restarted when JP drain was removed. I wrote that order today. R1's subsequent order, dated 4/10/26, identified directions which included taking Eliquis 2.5 mg orally twice a day. The order was signed by MD-A on 4/10/26 at 9:31 p.m., and the fax was time-stamped as received by the care center at 9:33 p.m. R1's Medication Administration Record (MAR), dated 4/2026, identified R1's administered medications for the month period. This included an order for Eliquis 2.5 mg twice a day with dates recorded, 04/11/2026 - 4/15/2026. The medication was recorded as not being administered on 4/11/26 for either dose with comments written, Other . pharmacy will deliver med ASAP, and Drug/Item unavailable. R1's first recorded dose of the Eliquis was on 4/12/26 in the morning (AM) hours. R1's progress note, dated 4/15/26, identified the nursing assistant (NA) reported R1 sat on her bedside and was unable to move her left leg. The note recorded the leg, . appeared to be difference [sic] in color and cooler than right side . resident said that she couldn't feel sensation on left foot. Called for ambulance and called daughter . left via ambulance When interviewed on 5/12/26 at 10:24 a.m., licensed practical nurse (LPN)-C reviewed R1's medical record and explained she was admitted to the care center following gallbladder surgery with a JP drain in place. LPN-C reviewed R1's Eliquis and stated the order to resume it was faxed to the center on 4/10/26 late in the evening and entered in the EMR to begin on 4/11/26. LPN-C acknowledged the doses on 4/11/26 were not (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered and expressed they were unsure why it wasn't given as a supply of Eliquis was available in the onsite emergency kit (E-kit). LPN-C retrieved a black-colored binder that had the E-Kit supply listed and Eliquis was included. LPN-C then showed the surveyor the medication room which had an AlixaRx machine present. On the front of the machine, a white-colored paper was taped with the medications available. Eliquis was listed and the paper was dated, 4-Nov-24. Further, LPN-C stated Eliquis was considered a high-risk medication and not getting the medication resumed timely when ordered would be a concern adding aloud, It's significant. On 5/12/26 at 1:59 p.m., unit nurse manager (RN)-B, the director of nursing (DON), and administrator were interviewed. DON explained the pharmacy sends medications to the campus once a day usually in the early morning hours, so an order received late at night wouldn't likely arrive the following day, however, the E-Kit was available and had some of that medication inside at the time on 4/11/26 to at least provide a dose. DON stated they would consider Eliquis to be a high-risk medication, and it should be given timely when ordered to help prevent blood clots.When interviewed on 5/12/26 at 2:32 p.m., MD-A stated they were the campus' medical director and reviewed R1's Eliquis. MD-A visited R1 on 4/10/26 and on that day learned it was to be restarted but were unsure if they identified that themselves or if the nurses at the center raised the issue with them. MD-A stated when they saw R1 on 4/10/26, there was no concern for a blood clot in her leg at that time, so the clotting most likely happened after that visit. MD-A stated if the medication was available in the E-Kit on 4/11/26 then a dose could have been removed and provided immediately following the order on 4/10/26 adding, That would be a med I would administer sooner rather than later. On 5/12/26 at 3:23 p.m., the dispensing pharmacist (DP)-A was interviewed and verified their service distributed the medications to the campus. DP-A stated their current formulary showed Eliquis as being available in the campus E-Kit, but they would have to check and then send a review of the retrospective inventory after the interview to confirm a medication supply was available on 4/11/26. DP-A stated nurses were always able to call them and ask about medication supply if they had questions about it. DP-A stated Eliquis was a medication the patient should not be without for a long period and explained the half-life of the medication (the time it takes for the concentration of that drug in your body to reduce by exactly 50%) was about 12 hours, and the medication starts working within an hour of being given. If a patient went for several days without it, then the effects of the medication would likely be totally removed from the body systems. DP-A stated having a period of multiple days between an order and actual administration would make a difference with the risk of blood clots being formed adding, It would matter something. An e-mail correspondence received from DP-A on 5/12/26 at 5:28 p.m., identified Eliquis was available with at least one dose in the E-Kit on 4/11/26. The email identified, It appears that the facility had a balance on hand in their [kit] to initiate therapy before the cards were delivered. A provided Emergency Pharmacy Service and Emergency Kits policy, dated 12/2017, identified emergency pharmacy services were available on a 24-hour basis through the approved emergency medication supply. The supply was maintained in the ADU (automated dispensing unit) room along with a list of supply and expiration dates. The policy then listed a procedure to withdraw and use the medication and document it on the medical record.