STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Care Community	201 9th Street West Ada, MN 56510

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to meet resident care requests timely and promote resident dignity for 4 of 4 residents (R1, R2, R4) when call lights were not answered timely.Findings include:R1's quarterly Minimum Data Set (MDS) dated [DATE], identified she had intact cognition and no behaviors. She had impaired ROM (range of motion) upper and lower extremities bilaterally and used a walker and wheelchair for mobility. She was dependent to roll left and right, sit to lying, lying to sit, sit to stand, and all transfers, and substantial/maximal assistance to walk 10 feet, personal/toilet hygiene, and upper/lower body dressing. She was frequently incontinent of bladder and always continent of bowel. Diagnoses included diabetes mellitus (DM), arthritis, and manic depression. R1's care plan dated 5/14/25, identified self-care deficit related to hemiplegia (one sided weakness) due to cerebrovascular accident (CVA) (stroke) with activities of daily living (ADL). Goal: resident will be continent of bladder 100% of the time within the next 90 days. She used stand PAL lift for transfers with assist of two and required toileting every two hours while awake to help remain free of skin breakdown and respect her dignity.R1's call light activity log report from 7/2/25 through 8/20/25, identified a range from 18 to 29 minutes record for 15 resident-initiated calls.During an interview on 8/19/25 at 10:10 a.m. R1 laid in recliner covered with a blanket. She stated staff would take up to 30 minutes to answer her call light at times. which resulted in her having urine accidents because she was unable to make it to the bathroom on time and wore a brief. R1 stated she felt embarrassed when she had to go in her pants and had to be changed be staff following an accident.R2's quarterly MDS dated [DATE], identified she had intact cognition. She had limited ROM lower extremity on one side and used a manual wheelchair for mobility. She required partial/moderate assistance with sit to lying and lying to sitting, and upper body dressing, substantial/maximal assistance with shower/bathing, toileting/personnel hygiene, lower body dressing, roll left and right, sit to stand, and all transfers. She was occasionally incontinent of urine and always continent of bowel. Goal: resident will be continent of bladder. Diagnoses included above the right knee amputation, DM, anxiety, and depression.R2's care plan dated 7/5/25 identified a self-care deficit and required assistance with ADL. She required assist of one and gait belt to transfer from wheelchair to/from toilet and toileting need addressed. She was occasionally incontinent, and staff were directed to offer assistance with toileting about every three hours while awake. Goal: resident will be continent 7 out of 7 days. R2's call light activity log report from 7/14/25 through 8/12/25, identified a range from 17 to 32 minutes record for 13 resident-initiated calls.During an interview on 8/20/25 at 1:25 p.m. R2 stated there were over 20 residents for two staff to take care of. She waited until she had more than one reason to call staff with call light so that they only had to come and assist her occasionally. The morning shift was quite busy, they need more help, had taken up to 30 minutes for staff to respond to her call light. She had sat in wheelchair, lacked muscle control, had bowel and bladder accidents daily. She was embarrassed when that happened especially when she was incontinent of bowel/stool, adding she had gone through three pairs of pants yesterday, R4's quarterly MDS dated [DATE], identified she had intact cognition with verbal behaviors directed towards others (e.g. threatening others, screaming at others, cursing at others) one to three times a week. She required partial/moderate assistance with lower body dressing, substantial/maximal assistance with personal hygiene, shower/bathing, sit to stand, all transfers, and walk 150 feet in corridor. She used a walker and manual wheelchair for mobility. She was frequently incontinent of bladder and always continent of bowel. Diagnoses included depression. R4's care plan dated 6/27/25, identified a self-care deficit with ADLs. She was frequently incontinent of urine. Goal: resident will be continent during the day within the next 90 days. She required extensive assistance of one with gait belt, wheeled walker to transfer, wipe, adjust clothing, and manage incontinence.R4's call light activity log report from7/5/25 through 8/19/25, identified a range from 21 to 50 minutes record for 18 resident-initiated calls.During interview and observation on 8/21/25 at 10:30 a.m., R4 sat in her wheelchair with a call light pendent around her neck. She stated just the other day she was taken to bathroom, staff had forgotten about her, left for the day, so she placed the call light on and waited at least 30 minutes. She was scared to get up by herself due to a recent fall. R4 indicated about once a week she had an accident of stool and urine because she was unable to get to the bathroom in time. She wore a brief, had messed her pants, which made her feel bad and embarrassed. R4 stated, who wants to show up with a dirty butt?Resident Council meeting minutes dated 5/13/25, identified department updates; concerns/comments - R2 was still being left in the bathroom for a

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure activities of daily living (ADLs) were provided for 4 of 4 residents (R1, R2, R3, R4) who required assistance with bathing. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified she had intact cognition and no behaviors. She had impaired range of motion (ROM) upper and lower extremities bilaterally and used a walker and wheelchair for mobility. She was dependent to roll left and right, sit to lying, lying to sit, sit to stand, and all transfers, and substantial/maximal assistance to walk 10 feet, personal/toilet hygiene, and upper/lower body dressing. Diagnoses included diabetes mellitus (DM), arthritis, and manic depression. R1's care plan dated 5/14/25, identified self-care deficit with bathing and personal hygiene. She would be clean and groomed. She required extensive assistance of one with bathing up to two times a week. R1's nursing assistant (NA) care sheet undated, bath day not identified. R1's Bath Schedule for the week of 8/17/25 through 8/23/25, identified bath day as Wednesday a.m. R1's progress notes from 6/1/25 through 8/18/25, identified skin assessments were completed on the following dates in the progress notes and no bath was identified: 6/5/25, 6/12/25, 6/19/25, 6/26/25, 7/3/25, 7/10/25, 7/17/25, 7/24/25. R1's progress notes from 6/1/25 through 8/17/25 identified skin assessments were completed on the following dates with a bath given: 7/31/25, 8/13/25, 8/20/25. R1's weekly skin checks completed from 6/5/25 through 8/20/25 identified a bath was given: 6/5/25, 6/12/25, 6/26/25, 7/3/25, 7/17/25, 7/24/25, 8/13/25, 8/20/25. R1's point of care (POC) NA documentation from 6/1/25 through 8/20/25, identified a tub bath was given 6/16/25, and 7/14/25. Summary of bath/shower documentation from 6/1/25 through 8/20/25 (11 weeks/3 days) identified: four bathes give in June, four bathes given in July, and two bathes given in August. During an observation/interview on 8/19/25 at 10:10 a.m., R1 laid in recliner, eyes closed, snoring. Woke up when name was spoken. She stated she received one whirlpool bath a week but would like more and her sister had asked staff for more. Her hair was frequently oily, felt dirty, and she felt embarrassed when she left her room. R1's hair was observed to be shine with an oily, straight and unkept appearance that hung down to her shoulders. During a second observation on 8/19/25 at 12:00 p.m., R1 sat at a dining room table with five other residents for lunch. Her hair again appeared oily, stringy, and unkept. During a third interview/observation on 8/19/25 at 1:38 p.m., R1 laid in bed covered with blankets. Two staff NAs entered the room and transferred her to wheelchair and brought her out to an activity. R1's hair appeared oily, unkept, straight, thin, and hung over her shoulders. During an observation/interview on 8/20/25 at 9:00 a.m., R1 was sitting in the dining room in her wheelchair with one other resident at the table. Her hair appeared oily and unkept. Activities director (AD) sat across the table assisting the other resident and verified R1's hair was oily but added that her hair can occasionally appear like that even after it was washed. Staff were working on trying to give all residents two bathes a week instead of only one. R1 stated she had placed her call light pendent on to let staff know she was ready for her bath. During an observation/interview on 8/20/25 at 9:46 a.m., registered nurse (RN)-D brought R1 into the tub room. She verified her hair was oily, and looked like this every day. During an observation/interview on 8/20/25 at 12:30 p.m., R1 laid in bed. Hair was brushed and appeared clean and not oily. She smiled and stated she was happy it did not look oily and felt so much cleaner. During an interview on 8/21/25 at 1:05 p.m. NA-A stated R1 received a bath yesterday and hair was washed. Today her hair looked better and clean, but the ends looked a little oily. R1's hair turned oily quickly and she would have benefitted from having her hair washed more often to prevent it from getting oily and looking dirty. R2's quarterly MDS dated [DATE], identified she had intact cognition. She had limited ROM lower extremity on one side and used a manual wheelchair for mobility. She required partial/moderate assistance with sit to lying and lying to sitting, and upper body dressing, substantial/maximal assistance with shower/bathing, toileting/personnel hygiene, lower body dressing, roll left and right, sit to stand, and all transfers. Diagnoses included above the right knee amputation, DM, anxiety, and depression. R2's care plan dated 7/5/25, identified a self-care deficit with ADL's: bathing and personal hygiene. She will be clean and well groomed. She required extensive assistance of one with bathing one time a week on Wednesdays. R2's NA care sheet undated identified bath day Wednesday and Saturday. R2's Bath Schedule for the week of 8/17/25 through 8/23/25, identified bath day as Monday a.m. R2's progress notes from 6/1/25 through 8/18/25, identified skin assessments were completed and no documentation of a bath: 6/3/25, 7/16/25, 7/21/25, 7/26/25, 8/11/25, 8/12/25, 8/18/25. R2's progress notes from 6/1/25 through 8/18/25, identified skin assessments and bath

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide restorative services for 4 of 4 residents (R1, R2, R3, R4) who discharge from Physical Therapy services with maintenance orders to maintain range of motion and conditioning. This had the potential to affect all 21 residents care planned for restorative therapy. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified she had intact cognition and no behaviors. She had impaired ROM upper and lower extremities bilaterally and used a walker and wheelchair for mobility. She was dependent to roll left and right, sit to lying, lying to sit, sit to stand, and all transfers, and substantial/maximal assistance to walk 10 feet, personal/toilet hygiene, and upper/lower body dressing. R1's care plan dated [DATE], identified activities of daily living (ADL) deficit and required restorative active range of motion (AROM): required passive range of motion (PROM) to left upper extremity three to six days a week. Staff were directed to complete PROM - shoulder flex, should abduction, elbow flex/extension, forearm supination (the forearm is rotated with assistance so the palm of hand faced upwards/prn (as needed) wrist flexion/extension. Ten reputations times one set up to six days a week once a day. She was unable to walk alone due to history of stroke and required restorative therapy: left knee brace, gripper socks, gait belt, right hand along the hallway railing, support under her left arm, followed with wheelchair with 25 feet at a time, up to two to three tries. She required AROM to upper extremities three to six days a week. Staff (certified nursing assistant/nursing) were directed to follow treatment guideline of occupational/physical therapy. Right upper extremity, two-pound shoulder flex, shoulder abduction, chest press, overhead press, 10 reputations times up to six days a week. R1's nursing assistant (NA) care sheet undated identified ambulation: therapy only. R1's PT discharge date d [DATE], identified had made good progress towards goals. Due to severity with cerebral vascular accident (CVA) (stroke) with left hemiplegia (complete or severe loss of voluntary movement on side of the body) she will continue to need assistance with all functional mobility. Continued to present with weakness decreased endurance, impaired balance, and impaired safety awareness. She required assist of one for transfers, bed mobility, and ambulation. She ambulates up to 24 feet with railing, knee brace, and moderate assistance of one. Her transfers were variable from minimum assist to maximum assist due to this nursing staff are using assist of two for transfers and EZ stand lift for toileting. Recommendations discussed with her and/or care giver the needed assist with all functional mobility. She was wheelchair bound for functional mobility. Recommend restorative nursing program (RNP) for ambulation. R1's restorative log dated [DATE] through [DATE], identified PROM and AROM signed off on [DATE], [DATE], and [DATE]. R1's point of care (POC) history documentation for RNP identified: -[DATE] through [DATE], number of days, active range of motion (AROM) was completed 6 out of 25 days. -[DATE] through [DATE], number of days for passive range of motion (PROM) was completed 6 out of 25 days. -[DATE] through [DATE], number of days walking was completed 0 out of 25 days. -[DATE] through [DATE], number of days of AROM was completed 12 out of 31 days. -[DATE] through [DATE], number of days PROM was completed 12 out of 31 days. -[DATE] through [DATE], number of days walking was completed 0 out of 31 days. -[DATE] through [DATE], number of days of AROM was completed 2 out of 20 days. -[DATE] through [DATE], number of days PROM was completed 2 out of 20 days. -[DATE] through [DATE], number of days walking was completed 0 out of 20 days. During an interview on [DATE] at 10:10 a.m. R1 stated she had not received any type of therapy/ROM with her left arm or any part of her boy for quite a while now. She had noted decreased strength and movement in that arm and wanted to check with provider to get an order for physical therapy (PT). R2's quarterly MDS dated [DATE], identified she had intact cognition and no behaviors. She had limited ROM lower extremity on one side and used a manual wheelchair for mobility. She required partial/moderate assistance with sit to lying and lying to sitting, and upper body dressing, substantial/maximal assistance with shower/bathing, toileting/personnel hygiene, lower body dressing, roll left and right, sit to stand, and all transfers. R2's care plan dated [DATE], identified restorative nursing: she was at risk for reduced mobility related to weakness and amputation of right leg lack of ability to ambulate. Nursing was directed to provide restorative nursing, seated, bilaterally upper extremities AROM with four-pound weight dowel 20 repetitions and downward and backward 20 repetitions up to six times a week. R2's PT notes dated [DATE], identified clinical impression: she was ablet o perform all functional transfers with minimum assist. Restorative aide also felt that she had returned to baseline. R2's PT patient's self-report of their current status dated [DATE], identified she was discharged from PT on this