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	09/25/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the 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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F 0580 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 interview and document review, the facility failed to promptly notify a physician of a change in condition for 1 of 3 residents (R1) reviewed when a left hip surgical incision showed signs of infection and required hospitalization. Findings include: R1's hospital Discharge summary dated [DATE], identified mechanical ground level fall after losing her balance and sustained a left subtrochanteric femur fracture. She required surgery that included an ORIF and tramedullary nailing of left femur. Surgical incision noted to left hip with dressing. R1's progress notes from 8/26/25 through 9/10/25, identified: -8/26/25 at 1:42 p.m. Skilled Nursing Documentation: Surgical wound left hip/thigh, no drainage, surrounding tissue intact and no pain. Nursing Interventions: surgical wound care. -8/26/25 at 8:33 p.m. Staples to left hip/thigh removed per order. R1 tolerated well. Cleansed area with saline and applied steri strips. -8/27/25, 8/28/25, 8/29/26, 8/30/25, Skilled Nursing Documentation completed. No documentation in progress notes on left hip/thigh incision (4 days). -9/1/25 at 8:43 a.m. Surgical wound left hip scant amount of purulent (thick and milky discharge from a wound and almost always indicates an infection, should not be ignored, and needs treatment as soon as possible) drainage. Surrounding tissue erythema (redness that occurs when extra blood rushes to an area and often indicates inflammation or infection). Pain was present with tenderness to upper aspect of incision. Nursing interventions: proper positioning and surgical wound care. -9/1/25 at 8:43 a.m. Skin Assessment: Skin check done prior to shower. Surgical incision to left hip is read and warm to upper half of incision. R1 does report some tenderness to area. Scant purulent drainage noted to two areas of upper incision: bottom area measuring 1.3 centimeters (cm) along incision and top area measuring 3 cm along incision. Cleansed with wound wash and patted dry. Waterproof surgical post op bandage applied. -9/1/25 at 11:59 a.m. as needed (PRN) Tylenol given at 12:00 p.m. per her request for pain. -9/1/25 at 2:19 p.m. Surgical wound left hip scant amount of purulent drainage, surrounding tissue erythema, and no pain. Interventions to promote healing and prevent infection: proper positioning and surgical wound care. -9/2/25 at 2:19 p.m. surgical wound left hip scant amount of purulent drainage, surrounding tissue erythema, and no pain. Interventions used to promote healing and prevent infection: positioning and surgical wound care. -9/3/25 at 4:07 p.m. R1 had red and warm to touch right foot/toes. Charge nurse sent picture to primary provider medical doctor (MD) who ordered Bactrim double strength (DS) two times a day (BID) times 7 days. Orders updated. -9/3/25 at 11:18 p.m. Skilled Nursing documentation completed. Skin and/or left hip incision was not included in this entry. -9/4/25 at 6:24 p.m. Nurse was asked to check left hip as was noted to be read and swollen today with pain. Started on Bactrim yesterday. Area or [sic] erythema and edema marked earlier. There was a Mepliex surgical in place with 430% [sic] serous drainage present to foam. The area marked has not spread and is 37 x 34 cm. There is a peau d [sic] orange skin texture. Skin is warm and erythematous. R1 reported it throbs and aches. Temperature 100.0 (F). Report sent to MD. Further vitals checked at within proximity to last check. No response from MD yet. Did report to oncoming nurse no response yet and encouraged to monitor vitals more frequently throughout the evening. Told R1 she may need an evaluation through the hospital and possible increase in antibiotics and she said no. When asked further she stated she did not wish to go to the hospital. She was informed a message was sent to the provider and that they would continue to monitor. Instructed to report feeling of chills or sweats. -9/4/25 at 7:11 p.m. MD responded thinking of a resident transfer to higher level of care. Awaiting orders for transfer to local ER vs another hospital. R1 agreed with transfer stated, if she had to. Nurse on duty was aware of pending transfer. Hand off report had been given. -9/4/25 at 7:28 p.m. R1 was transferred to local hospital via son. Bed holds in place. -9/5/25 at 8:43 a.m. Discussed at interdisciplinary team (IDT): transferred to local hospital due to worsening of infection of left hip. -9/10/25 at 10:55 a.m. R1's planned arrival date back to facility 9/10/25 around 11:30 a.m. to 12:00 p.m. admission diagnoses: sepsis due to post surgical abscess. Cares: peripherally inserted central catheter (PICC) (a long flexible catheter goes into your upper arm vein, through the vein in the arm and into a large vein located by the heart and allowed for long term access to infuse IV fluids, medications, and draw blood) line/antibiotic (Abx) for six weeks and wound vac/Prevena (not to be removed until batteries die) left hip. -9/10/25 at 12:35 p.m. R1 admitted from hospital in stable condition. -9/10/25 at 4:22 p.m. Skin assessment: left hip incision swollen and redness noted with wound vac in place. Left posterior calf open area 4 x 1 cm and 0.5 cm deep with clear drainage. Meplix dressing over Silvadene gauze ordered. R1's admission to hospital dated 9/5/25, identified admitted to hospital for post-surgical abscess and overlying abscess or

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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. (continued on next page)

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F 0684 Level of Harm - 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 ensure 1 of 3 residents (R1) received necessary medical attention following a change in a left hip surgical incision. Additionally, the facility failed to comprehensively assess, monitor, and document skin changes. R1 sustained actual harm and required hospitalization, surgery, and insertion of a peripherally inserted central line catheter (PICC) for intravenous (IV) antibiotic treatment for sepsis. Findings include: R1's hospital Discharge summary dated [DATE], identified mechanical ground level fall after losing her balance and sustained a left subtrochanteric femur fracture. She required surgery that included an surgical open reduction and internal fixation (ORIF) of the left hip and tramedullary nailing of left femur. Surgical incision noted to left hip with dressing. R1's progress notes from 8/25/25 through 9/10/25, identified: -8/25/25 at 2:57 p.m. Weekly Skin Check: R1 continued with stapes to surgical incision on the left hip/thigh. No new skin issues noted. -8/25/25 at 3:06 p.m. Skilled Nursing Documentation: Surgical wound left hip/thigh, no drainage, surrounding tissue intact and no pain. Nursing interventions: surgical wound care. -8/26/25 at 1:42 p.m. Skilled Nursing Documentation: Surgical wound left hip/thigh, no drainage, surrounding tissue intact and no pain. Nursing Interventions: surgical wound care. -8/26/25 at 8:33 p.m. Staples to left hip/thigh removed per order. R1 tolerated well. Cleansed area with saline and applied steri strips. -8/27/25, 8/28/25, 8/29/26, 8/30/25, Skilled Nursing Documentation completed. No documentation in progress notes on left hip/thigh incision (4 days). -9/1/25 at 8:43 a.m. Surgical wound left hip scant amount of purulent (thick and milky discharge from a wound and almost always indicates an infection, should not be ignored, and needs treatment as soon as possible) drainage. Surrounding tissue erythema (redness that occurs when extra blood rushes to an area and often indicates inflammation or infection). Pain was present with tenderness to upper aspect of incision. Nursing interventions: proper positioning and surgical wound care. -9/1/25 at 8:43 a.m. Skin Assessment: Skin check done prior to shower. Surgical incision to left hip is red and warm to upper half of incision. R1 does report some tenderness to area. Scant purulent drainage noted to two areas of upper incision: bottom area measuring 1.3 centimeters (cm) along incision and top area measuring 3 cm along incision. Cleansed with wound wash and patted dry. Waterproof surgical post op bandage applied. -9/1/25 at 11:59 a.m. as needed (PRN) Tylenol given at 12:00 p.m. per her request for pain. -9/1/25 at 2:19 p.m. Surgical wound left hip scant amount of purulent drainage, surrounding tissue erythema, and no pain. Interventions to promote healing and prevent infection: proper positioning and surgical wound care. -9/2/25 at 2:19 p.m. surgical wound left hip scant amount of purulent drainage, surrounding tissue erythema, and no pain. Interventions used to promote healing and prevent infection: positioning and surgical wound care. -9/3/25 at 4:07 p.m. R1 had red and warm to touch right foot/toes. Charge nurse sent picture to primary provider medical doctor (MD) who ordered Bactrim double strength (DS) two times a day (BID) times 7 days. Orders updated. -9/3/25 at 11:18 p.m. Skilled Nursing documentation completed. 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