| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245502 | A. Building<br>B. Wing | 03/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Benedictine Care Community | 201 9th Street West<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure physician notification of a change of condition for 1 of 3 residents (R1) reviewed who subsequently admitted to the hospital for septic shock.Findings include:R1's Annual Minimum Data Set, dated [DATE], identified intact cognition and indicated she did not display hallucinations, delusions or behaviors.R1's care plan identified a self-care deficit and a potential for infection related to urinary incontinence. The care plan directed staff to update the provider as needed. The care plan indicated R1 was alert and oriented and independent in making decisions.R1's Vitals Report identified the following:2/21/26-10:32 a.m. temperature (Temp) 101.7 degrees Fahrenheit (F), pulse 140 beats per minute (bpm)-11:37 a.m. Temp 103.2 degrees F.-1:02 p.m. Temp 101.6 degrees F.-5:18 p.m. Temp 100.2 degrees F.2/22/26-9:50 a.m.-pulse (P) 109 bpm.-9:50 a.m. Temp 99.4 degrees F.-4:55p.m.- Temp 100.1 degrees F.2/23/26-8:50a.m. Temp 99.1 degrees F, P 102 bpm.-3:42 p.m. Temp 100 degrees F.R1's Physician Order Report indicated she was administered acetaminophen 1000 milligrams three times daily.R1's Progress Notes indicated the following:-2/19/26, R1 had not slept, was in and out of her room and hollering at her phone about murdering her babies.-2/19/26, R1 suddenly started yelling and crying stating they want to take my babies from me and stated her family member texted her and said she would see her in heaven at which point R1 was sobbing uncontrollably.-2/19/26, Interdisciplinary (IDT) discussed R1's behavior of throwing a water pitcher, wanted to cancel appointment and was hallucinating.-2/21/26, R1 stated she had been vomiting all night and stated she was in so much pain she could hardly move.-2/21/26, R1 was visibly shaking and cold in the morning. Vitals signs normal except for Temp which was 101 degrees F. Tylenol was given and Temp repeated and remained 101 degrees F.-2/22/26, R1 had episodes of incontinent diarrhea and was running a low-grade fever of 99 degrees F. R1 reported pain everywhere, was tearful and crying and stated she wanted to leave.-2/22/26, R1's had Temp 100.1 degrees F., Tylenol given.-2/23/26, IDT discussed R1's fevers over the weekend, feeling tired, refusing medications and verbal behaviors toward staff. Staff would assess R1 and contact provider if necessary.-2/23/26, R1 was lying in bed and reported not eating dinner and feeling very tired. Writer checked vitals at this time. Temp was 100 degrees F.-2/23/26, R1 did not eat dinner but ate some pudding. R1 did not want any medications.-2/24/26, R1 was shivering at this time stating she was cold. Temperature was 99.2 degrees F, color was pale with a grey hue, dark circles under her eyes. R1 stated she hurt all over and stated just did not feel well. Ambulance called and R1 was sent to emergency department (ED) for evaluation.-2/25/26, R1 had been transferred to hospital with diagnosis of sepsis.R1's ED Provider Notes dated 2/24/26, indicated R1 had been brought to the ED after becoming drowsier and unresponsive. R1's temperature was 102.8 degrees F. R1 had started a fever on Friday (2/20/26). Physical appearance indicated ill-appearing, and toxic-appearing. Cardiovascular indicated tachycardia (a resting heart rate that is too fast, typically over 100 bpm in adults, resulting from an abnormal electrical signal in the heart). ED course indicated intravenous (IV) fluids were started and R1 started to develop hypotension (low blood pressure) and R1 had GFR [glomerular filtration rate] a medical test that measures how well your kidneys filter<br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245502 | A. Building<br>B. Wing | 03/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Benedictine Care Community | 201 9th Street West<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | blood, acting as a key indicator of kidney function) was quite low. R1 received IV antibiotics and had a urinary tract infection. Due to R1 showing signs of sepsis, she needed to be transferred to a higher level of care. Problems addressed included acute kidney injury, ureteral obstruction and sepsis with acute renal failure and septic shock.R1's Hospital discharge paperwork identified the principal problem as sepsis due to E-coli with acute organ dysfunction and septic shock and urinary tract infection secondary to obstructing left ureteral stone.During interview on 3/4/26 at 9:20 p.m., the physician said staff had not contacted her when R1 had the change of condition. The physician said people could have bladder stones for years but said when she developed a fever staff should have contacted her. The physician said the septic shock could have been avoided.During interview on 3/4/26 at 9:20 a.m., medical doctor (MD)-A confirmed staff had not notified her of R1's change of condition. MD-A stated she should have been contacted when R1 developed a fever. MD-A said R1's septic shock would have been avoided.During interview on 3/4/26 at 11:47 a.m., registered nurse (RN)-B stated staff should have notified the provider of R1's change of condition.Facility policy Change in Condition, Resident Examination and Evaluation dated 11/10/25, indicated when a significant change in the resident's physical, mental or psychological status is identified by the licensed nurse, or when there is a need to alter treatment significantly, the licensed nurse consults with the attending provider and notifies the resident representative. Notify the provider of change of condition and implement orders for treatment and appropriate monitoring as directed. Notify the provider of any abnormalities such as, but no limited to, abnormal vital signs, change in behavioral of neurological condition, worsening pain reported by the resident. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245502 | A. Building<br>B. Wing | 03/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Benedictine Care Community | 201 9th Street West<br>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 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to identify and act on a change of condition for 1 of 3 residents (R1) who was care planned for potential infections, had a fever and was experiencing hallucinations which was an atypical symptom.ˆ This delay in treatment resulted in an immediate Jeopardy (IJ) for R1 when she was diagnosed with sepsis and was hospitalized . The IJ began on 2/21/26, when R1's vital signs indicated a temperature of 101.7 degrees Fahrenheit (F) and she was demonstrating other signs of illness such as vomiting, visible shaking, hallucinations, disruptive behavior, reports of pain, and crying with no nursing assessment conducted and the provider was not contacted.ˆ R1's symptoms continued until she was brought to the emergency department (ED), had a temperature of 102.8 degrees F, a physical appearance described as ill and toxic appearing and was diagnosed with septic shock and had to be hospitalized .ˆThe administrator was notified of the immediate jeopardy at 4:30 p.m. on 3/4/26.ˆˆThe immediate jeopardy was removed on 3/5/26, but noncompliance remained at the lower scope and severity level ofˇD,ˆwhich indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's annual Minimum Data Set, dated [DATE], identified intact cognition and indicated she did not display hallucinations, delusions or behaviors. R1's care plan identified a self-care deficit and a potential for infection related to urinary incontinence. The care plan directed staff to update the provider as needed. The care plan indicated R1 was alert and oriented and independent in making decisions. R1's Vitals Report identified the following: 2/21/26 -10:32 a.m. temperature (Temp) 101.7 degrees Fahrenheit (F), pulse 140 beats per minute (bpm) -11:37 a.m. Temp 103.2 degrees F. -1:02 p.m. Temp 101.6 degrees F. -5:18 p.m. Temp 100.2 degrees F. 2/22/26 -9:50 a.m.- pulse (P) 109 bpm. -9:50 a.m. Temp 99.4 degrees F. -4:55p.m.- Temp 100.1 degrees F. 2/23/26 -8:50a.m. Temp 99.1 degrees F, P 102 bpm. -3:42 p.m. Temp 100 degrees F. R1's Physician Order Report indicated she was administered scheduled, acetaminophen 1000 milligrams three times daily for pain. R1's Progress Notes indicated the following: -2/19/26, R1 had not slept, was in and out of her room and hollering at her phone about murdering her babies. -2/19/26, R1 suddenly started yelling and crying stating they want to take my babies from me and stated her family member texted her and said she would see her in heaven at which point R1 was sobbing uncontrollably. -2/19/26, Interdisciplinary team (IDT) discussed R1's behavior of throwing a water pitcher, wanted to cancel appointment and was hallucinating. -2/21/26, R1 stated she had been vomiting all night and stated she was in so much pain she could hardly move. -2/21/26, R1 was visibly shaking and cold in the morning. Vitals signs normal except for Temp which was 101 degrees F. Tylenol was given and Temp repeated and remained 101 degrees F. -2/22/26, R1 had episodes of incontinent diarrhea and was running a low-grade fever of 99 degrees F. R1 reported pain everywhere, was tearful and crying and stated she wanted to leave. -2/22/26, R1's had Temp 100.1 degrees F., Tylenol given. -2/23/26, IDT discussed R1's fevers over the weekend, feeling tired, refusing medications and verbal behaviors toward staff. Staff would assess R1 and contact provider if necessary. -2/23/26, R1 was lying in bed and reported not eating dinner and feeling very tired. Writer checked vitals at this time. Temp was 100 degrees F. -2/23/26, R1 did not eat dinner but ate some pudding. R1 did not want any medications. -2/24/26, R1 was shivering at this time stating she was cold. Temperature was 99.2 degrees F, color was pale with a grey hue, dark circles under her eyes. R1 stated she hurt all over and just did not feel well. Ambulance called and R1 was sent to emergency department (ED) for evaluation. -2/25/26, R1 had been transferred to hospital with diagnosis of sepsis. ˆ R1's ED Provider Notes dated 2/24/26, indicated R1 had been brought to the ED after becoming drowsier and unresponsive. R1's temp was 102.8 degrees F. R1 had started a fever on Friday (2/20/26). Physical appearance indicated ill-appearing, and toxic-appearing. Cardiovascular indicated tachycardia (a resting heart rate that is too fast, typically over 100 bpm in adults, resulting from an abnormal electrical signal in the heart). ED (continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245502 | A. Building<br>B. Wing | 03/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Benedictine Care Community | 201 9th Street West<br>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 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | course indicated intravenous (IV) fluids were started and R1 started to develop hypotension (low blood pressure) and R1 had GFR [glomerular filtration rate]ˆa medical test that measures how well your kidneys filter blood, acting as a key indicator of kidney function) was quite low. R1 received IV antibiotics and had a urinary tract infection. Due to R1 showing signs of sepsis, she needed to be transferred to a higher level of care. Problems addressed included acute kidney injury, ureteral obstruction and sepsis with acute renal failure and septic shock. R1's Hospital discharge paperwork identified the principal problem as sepsis due to E-coli with acute organ dysfunction and septic shock and urinary tract infection secondary to obstructing left ureteral stone. During observation and interview on 3/3/26 at 3:03 p.m.,ˆR1 was seated in a recliner chair in her room. R1 stated the Friday before she went to the hospital she had gotten her pills, then started throwing up. R1 stated prior to going to the hospital, she really did not remember anything. R1 said at the hospital they told her she had kidney stone and placed a stent and said she had been really sick. During interview on 3/3/26 at 4:39 p.m., registered nurse (RN)-D stated she had worked with R1 and said she had not identified anything out of the ordinary other than R1 complained of feeling weak and had been running a low-grade fever. RN-D said she contributed her symptoms to R1 possible having influenza. RN-D said one morning when R1's temperature was checked it was 98.2 degrees F, and with the presumption of R1 having influenza it was thought maybe R1 was getting over it. RN-D stated the nurses had conversations between incoming and outgoing shifts about R1's condition and she had been told at the beginning of her shift on Monday, R1 was not feeling better and if it continued she night need to be sent to the ED. RN-D said the morning R1 was sent to the ED, she had checked on R1 and said her color did not look good and she complained of having pain all over so she had called 911. During interview on 3/4/26 at 9:20 a.m., medical doctor (MD)-A said staff had not contacted her when R1 had the change of condition. The MD stated people could have bladder stones for years with urinary tract infections that came and went but said when stone pain started it was important to be seen right away. MD-A stated the facility should have contacted her when R1 developed a fever. Adding, if they had, R1's septic shock would have been avoided. During interview on 3/4/26 at 10:01 a.m., nurse practitioner (NP) stated R1 arrived at the ED early in the morning and had been barely responsive. NP stated the ED staff were about to intubate but R1 perked up with intravenous fluids and vasopressors. NP stated R1 was very sick and said her blood pressure had dropped which indicated the use of vasopressors and R1's kidneys were in bad shape. The NP indicated R1 had a large stone she could not pass on her own with puss behind it that was drained and, while the stone would had not have been avoidable, the sepsis and unnecessary pain could have been prevented if R1 had been sent to the ED sooner. During interview on 3/4/26 at 10:36 a.m., RN-C stated if a resident displayed a change of condition, she would start with checking vital signs and comparing them to the resident's baseline, completing a general assessment and then reporting to the nurse managers. RN-C said prior to R1 going to the hospital, she had come to work in the morning and R1 had reported not sleeping. RN-C stated R1 had been crying and talking about her daughter. RN-C said R1 had been hallucinating, which was not normal. RN-C stated she had spoken to R1's family member (FM) and RN-A about R1 that day. During interview on 3/4/26 at 11:24 a.m. RN-A said R1's change in condition happened over the weekend and said the IDT was not there on the weekend which was part of the problem. RN-A said R1 was discussed during the IDT meeting on Monday but said they did not review the progress notes or R1's vital signs. During interview on 3/4/26 at 11:47 a.m., RN-B said when a change of condition occurred, depending on the change, staff should assess and monitor. RN-B said she had not assessed R1 on 2/23/26, following the IDT discussion and said she had gone to R1's room but she had been asleep and her temp had been down to 99.1 degrees F. RN-B stated she felt the IDT missed R1's change of condition because her diagnosis of Bipolar and previous behaviors had masked the change and said it had interfered with their judgement. RN-B further stated staff should have notified the physician about R1's elevated temperature over the weekend. Facility policy Change in Condition, Resident Examination and Evaluation dated 11/10/25, indicated a thorough resident examination will<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245502 | A. Building<br>B. Wing | 03/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Benedictine Care Community | 201 9th Street West<br>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 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | capture any abnormalities in health status, physical function and acute change of condition. Procedure: Licensed nurses within their scope of practice standards, evaluate for a significant change of condition through direct observation/physical examination that is outside of baseline findings including interview or report from other staff. Obtain vital signs. Notify the provider of change of condition and implement orders for treatment and appropriate monitoring as directed. Notify the provider of any abnormalities such as, but no limited to, abnormal vital signs, change in behavioral of neurological condition, worsening pain reported by the resident. ˆ The immediate jeopardy that began onˆ2/21/26ˆwas removed on 3/5/26, after the facility implemented a systemic plan that included the following actions:ˆˆ Review of Policy and Procedures related to Change in Condition and Physician Notification. Reviewed all residents for a potential change in condition. Education to nursing staff onˆidentification of policies and procedures related to change of condition and resident monitoring, qualifying factors for a change of condition as well as assessment of the resident symptoms (removing bias of resident behaviors/baseline) and timely notification of Physician and treatment of resident symptoms. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245502 | A. Building<br>B. Wing | 03/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Benedictine Care Community | 201 9th Street West<br>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 0882<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.<br><br>Based on interview and document review, the facility failed to ensure the infection preventionist (IP) completed the required training for the role of IP.Findings include: RN-B's record of completed training was reviewed and lacked evidence of training related to the role of IP. During interview on 3/5/26 at 2:22 p.m., registered nurse (RN)-B stated she was the facility designated IP. RN-B stated she had started the required training but had not had time to finish.Facility policy Infection Preventionist Role dated 8/2023, indicated the IP or designee is responsible for directing the infection prevention and control program within the facility. The IP should have a background and training appropriate for carrying out these responsibilities, have a primary professional training in nursing, medical technology, microbiology, epidemiology or other related field, be qualified by education, training, certification or experience, and have completed specialized training in infection prevention and control. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245502 | A. Building<br>B. Wing | 03/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Benedictine Care Community | 201 9th Street West<br>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 0943<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.<br><br>Based on interview and document review the facility failed to ensure annual abuse training was completed for 2 of 10 staff reviewed for training.Findings Include:Nursing assistant (NA)-A had a hire date of 11/7/25. NA-A's record of Completed Training printed 3/5/26, indicated she had not completed annual abuse training.Registered nurse (RN)-B had a hire date of 8/28/24. RN-B's record of Completed Training printed 3/5/26, indicated she had not completed annual abuse training since 8/28/24.During interview on 3/5/26 at 1:41 p.m., the human resources manager (HRM) stated the mangers were responsible to ensure their staff completed training. The HRN said the corporate office sent messages quarterly regarding required trainings and she reminded the managers. The HRM said she did not track who had or had not completed required training.Facility policy Regulatory and Compliance Education dated 5/1/24, indicated each community should assign an associate the responsibility of the super registrar role. This person is to manage the tracking of the training system. Assigned hire courses should be completed before an associate works independently on the floor. Annual requirements are established according to licensure, certification and/or role-based requirements and are assigned quarterly. |