



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 31, 2026

Administrator
BENEDICTINE HEALTH CENTER INNSBRUCK
1101 BLACK OAK DRIVE
NEW BRIGHTON, MN 55112

Re: Reinspection Results
Event ID: 2AB1D6-H2

Dear Administrator:

On August 18, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 27, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 3, 2026

Administrator

BENEDICTINE HEALTH CENTER INNSBRUCK

1101 BLACK OAK DRIVE

NEW BRIGHTON, MN 55112

RE: CCN: 245310

Cycle Start Date: June 25, 2026

Dear Administrator:

On July 8, 2026, we informed you that we may impose enforcement remedies.

On July 27, 2026, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 25, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 25, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 25, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed

care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 25, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, BENEDICTINE HEALTH CENTER INNSBRUCK will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 25, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

**Tina Larsen, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
St. Cloud District Office
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Tina.Larsen@state.mn.us
Office: (320) 223-7374 Mobile: (320) 423-0619**

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 25, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security

Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
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August 3, 2026

Administrator

BENEDICTINE HEALTH CENTER INNSBRUCK

1101 BLACK OAK DRIVE

NEW BRIGHTON, MN 55112

Re: State Nursing Home Licensing Orders

Event ID: 2AB1D6-H1

Dear Administrator:

The above facility survey was completed on July 27, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Tina Larsen, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
St. Cloud District Office
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Tina.Larsen@state.mn.us
Office: (320) 223-7374 Mobile: (320) 423-0619

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245310		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/27/2026	
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK				STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE , NEW BRIGHTON, Minnesota, 55112			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 7/27/26, an abbreviated survey was completed by a surveyor from the Minnesota Department of Health (MDH) to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, the Requirements for Long Term Care Facilities. The following complaint was reviewed: H53103480C (3109360); with non-compliance cited at F609, F684, F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.			F0000			08/10/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established			F0609	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R4 was interviewed by the facility administrator. An investigation was completed and the allegation was deemed unsubstantiated. The DON/designee reviewed the residents with portable oxygen needs who were cared for by the CNA named in the allegation, including a review of progress notes and care plans for evidence of unreported concerns. No additional unreported allegations of abuse, neglect, or mistreatment were identified during this audit. All staff will be re-educated on Benedictine Innsbruck's Abuse Prevention Plan, with specific emphasis on the requirement for immediate verbal		08/10/2026

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 reverse for further 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 CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245310		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/27/2026	
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK				STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE , NEW BRIGHTON, Minnesota, 55112			
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F0609 SS = D	Continued from page 1 procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a voiced allegation of potential neglect of healthcare was immediately reported to the administrator, or designee, then reported to the State agency (SA) within 24 hours for 1 of 4 residents (R4) reviewed. R4 alleged nursing assistant (NA)-D had “deliberately” connected her to an empty oxygen tank and wouldn’t fill it when told it was empty. R2 then experienced shortness of breath and had low oxygen saturation levels due to no oxygen in the tank. Findings include: R4’s annual Minimum Data Set (MDS), dated 5/18/26, identified R4 had intact cognition and did not have delusional thinking (i.e., believing things which are not true). R4 had multiple medical conditions including coronary artery disease (CAD) and respiratory failure. R4’s care plan, last revised 7/22/26, identified R4 had an alteration in respiratory status and directed staff to encourage compliance with oxygen use and keep the portable tank filled every shift. R4 was a vulnerable adult due to admission to the skilled nursing facility (SNF), and the plan directed to report and investigate allegations of suspected abuse, neglect, or exploitation. The care plan lacked evidence R4 had a history of false allegations against staff about abuse or neglect. R4’s Search Vitals Results – 02 Saturation, printed 7/27/26, identified R4’s recent oxygen saturation (the percentage of hemoglobin in the blood carrying oxygen; normal levels range from 95% to 100% and low values indicate hypoxemia) levels recorded in her medical record. From 7/1/26 to 7/4/26, the recorded saturation levels ranged from 91 to 98%. R4’s progress note, dated 7/5/26, identified R4 was sitting in the dining room and suddenly stated, “I can’t breathe.” R4 had blue-colored lips and a			F0609	Continued from page 1 reporting of any allegation of abuse, neglect, exploitation, or mistreatment to the Administrator/DON without delay, followed by timely reporting to the State Survey Agency in accordance with regulatory timeframes. All nursing staff were reeducated on ensuring all portable oxygen tanks were filled per Facility policy/procedure. The DON/designee will audit all progress notes weekly for four (4) weeks to identify any “red flag” documentation suggestive of an unreported allegation of abuse, neglect, exploitation, or mistreatment. Results of these audits will be reviewed at monthly Quality Council meetings. The QAPI Committee will determine whether continued monitoring, additional education, or further systemic changes are warranted based on audit findings. The QAPI Committee will determine whether continued monitoring, additional education, or further systemic changes are warranted based on audit findings. The Administrator / Designee are responsible for ensuring ongoing compliance with this plan of correction. Completion Date: August 10, 2026		08/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245310		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/27/2026	
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F0609 SS = D	Continued from page 2 headache, and her oxygen saturation was 75%. The nurse immediately took R4 back to her room and connected her to her oxygen machine. The note recorded, "[R4] stated, the [NA] who assist her in the morning deliberately connected her to an empty potable [sic] tank and refused to fill it after she being [sic] informed that the tank was empty." The note continued and recorded the NA stated they didn't have time to fill it when told it was empty and "... walked away, leaving the resident connected to an empty patable [sic] tank." The note was authored by licensed practical nurse (LPN)-E and lacked any further text or dictation showing what, if any, investigation into the allegation was done to determine if the accusation was credible. The Centers for Medicare and Medicaid (CMS) Internet Quality Improvement and Evaluation System (iQIES) database lacked evidence that the allegation written in R4's medical record had been reported to the SA. Further, R4's medical record was reviewed and lacked evidence the allegation of potential neglect had been reported to the administrator on 7/5/26 despite the recorded progress note. R4 was hospitalized at the time of the abbreviated survey (exited 7/27/26) and unavailable for interview. When interviewed on 7/27/26 at 2:55 p.m., LPN-E stated they recalled the event on 7/5/26 and explained R4 had reported to them the NA had not filled her oxygen tank. When asked about the word 'deliberately' in the progress note, LPN-E stated aloud, "That's what she told me." R4 had told the NA the tank was empty, and the NA still didn't fill it. LPN-E stated they could not recall what, if any, further investigation they did into that allegation as "my focus" was just on getting R4 reattached to oxygen. LPN-E stated they have a supervisor on-duty over the weekend hours and was unable to recall if they had reported the allegation to them or not. LPN-E stated if someone needed oxygen and was deliberately not given it that it would be not good, but they were hesitant to accuse someone of neglect for that as other factors may be involved. LPN-E reiterated the dictation in the progress note was just R4's voiced words adding, "I was quoting my patient." On 7/27/26 at 3:32 p.m., the administrator and director of nursing (DON) were interviewed. They acknowledged being aware of R4's note (dated 7/5/26), and the administrator stated he had discovered it during a random audit of progress notes on 7/7/26. That was the first time he learned of the allegation. He then emailed the nurse manager			F0609			08/10/2026

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F0609 SS = D	Continued from page 3 to follow-up about it and did an investigation into the situation which was unsubstantiated. The DON stated staff should inform leadership “right away” of allegations of potential abuse or neglect, however, that did not happen in this situation as the nurse who heard the comment then “did not let anybody know.” The DON stated anytime an allegation is heard that they’d expect it to be reported to leadership. The administrator reiterated they felt the allegation to be unsubstantiated based on their review of it after learning about it; however, he stated that any allegation of neglect should be reported up to leadership so it could be reviewed. He added, “We should be following our policy.” Further, the administrator stated he questioned the wording choices in the progress note by the nurse and, again, felt the situation was maybe not accurately captured in those words. The facility Abuse Prevention Plan, dated 2/2024, identified new and existing staff would be trained in abuse and neglect prevention. The medical records would also be routinely monitored for indicators of potential abuse or neglect, and that any person with knowledge of suspected abuse or neglect should report it immediately. The policy directed the person-in-charge was to be notified “immediately” of ay reports who would then notify the administrator and other leadership. If the event didn’t cause serious bodily injury or harm, then it should be reported to the SA within 24 hours after the suspicion was identified.			F0609			08/10/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to implement adequate nursing monitoring of a potential respiratory condition to help prevent complication (i.e., worsening) for 1 of 4 residents (R1) reviewed. R1 developed a semi-productive cough which required medication and diagnostic			F0684	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. The patient discharged from the facility on 2/1/2026 and is no longer under the facility's care DON/designee audited patients with an order for chest x-ray due to cough to confirm that vital signs, including lung assessment, were documented and that provider recommendations were implemented. Any patient found with an outstanding or incompletely followed-through recommendation was assessed and addressed immediately. All licensed nursing staff were re educated on the		08/10/2026

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F0684 SS = D	Continued from page 4 evaluation; however, no further ongoing vital sign or lung function monitoring was placed or recorded to ensure it resolved. Findings include: R1's admission Minimum Data Set (MDS), dated 1/14/26, identified R1 had intact cognition, demonstrated no rejection of care behaviors, and had multiple medical conditions including chronic lung disease. R1's M Health Fairview Geriatrics progress note, dated 1/23/26, identified R1 was evaluated by the medical provider at the care center. R1's past medical history included severe protein-calorie malnutrition, pain, and history of bone fractures with routine healing. R1's fractures had an x-ray completed and her pain was controlled. The note recorded, "Overall doing well." A physical exam was recorded which identified, "RESP: lungs clear to auscultation, no respiratory distress." The note lacked evidence that R1 had complaints or current concerns about a productive cough. R1's progress note, dated 1/24/26, identified R1's tube feedings were all discontinued by provider order. R1's progress note, dated 1/26/26, identified R1's vitals were stable and she had "no shortness of breath noted, lung sounds clear." However, R1's subsequent M Health Fairview Geriatrics progress note, dated 1/27/26, identified R1 was evaluated by the same provider (as 1/23) at the care center. R1's medical history now recorded, "Cough, unspecified type." R1 had a coarse semi-productive cough, was afebrile, and had no apparent aspiration. A physical exam was completed which recorded, "RESP: no respiratory distress, crackles bronchial." The provider ordered guaifenesin (an expectorant medication used to loosen mucus in the airways) and another chest x-ray. R1's progress note, dated 1/28/26, identified the x-ray results were received which recorded the lungs free of infiltrates or focal consolidations. However, there was a small loculated left pleural effusion (localized pocket of fluid). R1's subsequent M Health Fairview Geriatrics progress note, dated 1/30/26, identified R1 was evaluated by the same provider (as 1/23, 1/27) at the care center for follow-up. R1's cough remained with mild wheezes noted, but oxygen saturations over 90% on room air. The x-ray results (dated 1/28) were reviewed and considered "clean," and R1 remained afebrile. The provider ordered albuterol nebulizer			F0684	Continued from page 4 facility's Change of Condition process, with specific emphasis on nurse practitioner/physician recommendations and the expectation for timely assessment, provider communication, implementation of recommendations, documentation, and follow-up. New hire orientation and annual competency validation will be updated to include this content going forward. A process will be implemented for licensed nursing staff to acknowledge and document completion of provider recommendations at the time they are received, with escalation to the DON/designee if not completed within the expected timeframe. DON/designee will audit 5 nurse practitioner/physician recommendations per week for four consecutive weeks to verify timely assessment, provider communication, implementation, and documentation, then will conduct audits on a sample basis monthly for two additional months. Results of these audits will be reviewed at monthly Quality Council meetings. The QAPI Committee will determine whether continued monitoring, additional education, or further systemic changes are warranted based on audit findings. DON/designee are responsible for ensuring ongoing compliance with this plan of correction. Completion Date: August 10, 2026		08/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245310		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/27/2026	
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK				STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE , NEW BRIGHTON, Minnesota, 55112			
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F0684 SS = D	Continued from page 5 treatments four-times-a-day and directed, “repeat CXR [x-ray] if not improving.” R1’s progress note, dated 2/1/26, identified R1 had breathing problems and listed her vital signs as 129/89 (BP), 98.0 (F), and oxygen level at 75%. The head of bed was raised and oxygen was applied. The on-call provider and family were notified. R1 was transferred to the acute care hospital. R1’s Search Vitals Results, dated 1/25/26 to 7/27/26, identified R1’s collected and recorded vital signs from those dates. This identified that from 1/27 (when the cough was identified by the provider) until 2/1 (when R1 transferred to the hospital) that only two vital signs were taken. These were recorded as: 01/28/26 – Weight – “Not Taken.” 01/30/26 – O2 Saturation – “94%.” R1’s medical record was reviewed and lacked evidence any other vital signs were recorded between 1/27/26 and 1/30/26; nor any evidence of what, if any, nursing monitoring of the developed cough was being done (i.e., lung sounds) to ensure it resolved and did not worsen which would possibly warrant additional x-ray diagnostics per the provider. When interviewed on 7/27/26 at 10:16 a.m., R1’s family member (FM)-A stated R1 admitted to the care center from the hospital and voiced multiple concerns about the care provided to R1 during their admission. R1 had developed a cough which was potentially from her tube feeding so the center did a chest x-ray which was normal early on. R1 continued to have a cough though and just get “sicker and sicker” which led to another x-ray being done which FM-A had been told was normal. However, it showed a pleural effusion and R1 continued with the coughing episodes. FM-A stated they had R1’s medical records and questioned the lack of recorded monitoring of R1’s respiratory function despite multiple x-rays being done and R1 seeming to get worse at the end of her admission. FM-A stated the cough was a “deep, gurgly cough” and staff were aware of it including the provider. When interviewed on 7/27/26 at 12:15 p.m., licensed practical nurse (LPN)-B stated the response to a resident with a developed cough would be determined if it was a “simple” or not. If a more productive or forceful cough, then the unit managers would be notified, and they’d develop the plan for			F0684			08/10/2026

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F0684 SS = D	Continued from page 6 monitoring. LPN-B stated they would just “make it known to the higher ups” of a developed productive cough and they’d act on it. LPN-B stated they did not recall ever working with R1 while she had been admitted to the care center. On 7/27/26 at 1:55 p.m., the director of nursing (DON) and registered nurse manager (RN)-H were interviewed. DON explained R1 was a “complex patient” and had norovirus just prior to being admitted to the care center. DON felt R1’s cough was more chronic versus acute and explained that monitoring of a respiratory condition should include vital signs being done every shift. If concerns with the vital signs, then a more in-depth assessment could be done such as lung sounds. DON reviewed the medical record and verified it lacked evidence of vital signs being monitored every shift after 1/27/26, despite R1 having an identified cough by the provider. DON stated they felt some education for the nurses would be helpful, adding it was important to ensure a change of condition is monitored to ensure the condition improves and does not worsen. The facility Change in Condition, Resident Examination and Evaluation policy, dated 11/2025, identified the facility would complete an evaluation upon admission, with a change in physical function, and with an acute change of condition. If a significant change was identified, the provider would be notified. A procedure was listed which directed a nurse to evaluate for a change, review the medical record, notify and supervisor and obtain a set of vital signs as needed/ordered. The policy then directed to notify the IDT and, “Monitor and provide treatment as ordered by the attending provider.” However, the policy lacked dictation on what ongoing monitoring would include or how it would be recorded in the medical record.			F0684			08/10/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and			F0686	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. The patient discharged from the facility on 2/1/2026 and is no longer under the facility's care All residents with current active wounds were identified and immediately reviewed to confirm weekly wound measurements and assessments were		08/10/2026

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F0686 SS = D	Continued from page 7 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a stage III pressure ulcer (i.e., full-thickness skin loss) was accurately documented and adequately monitored for healing with weekly measurements and characteristic evaluations to promote continuity of care and reduce the risk of complication (i.e., worsening) for 1 of 4 residents (R1) reviewed. Findings include: R1's admission Minimum Data Set (MDS), dated 1/14/26, identified R1 had intact cognition, was not diabetic, and demonstrated no refusal of care behaviors. Further, R1 had a current stage III pressure ulcer which was present on admission, and she remained at risk of continued pressure ulcer development. R1's progress note, dated 1/8/26, identified R1 admitted to the care center and had a tube feeding present. R1 had a history of malnutrition, pain and atrial fibrillation. R1 refused a skin check. R1's progress note, dated 1/9/26, identified the nurse completed a skin inspection. R1 had a Stage III pressure injury on her coccyx with slough (dead, non-viable tissue) present in the wound bed. It measured 1.9 X 2.0 centimeters (cm) in size and was likely from friction and/or shearing as R1 spent much of her time in bed. A subsequent note, dated 1/9/26, identified R1 was incontinent of bowel and used a Foley catheter. R1's Skin Risk Observation with Braden Scale, dated 1/11/26, identified R1 to be at risk of pressure ulcer development. R1 had several risk factors including acute condition, malnourishment, and needing help to complete mobility activities such as turning side to side. The evaluation identified R1 had current, unhealed pressure injury on her sacral region along with moisture-associated skin damage (MASD) present. A new care plan would be established, and referrals were placed to dietary and therapies. R1's care plan, dated 1/12/26, identified R1 had an alteration in her skin integrity evidence by a stage III			F0686	Continued from page 7 up to date and documented in accordance with physician orders and facility policy. Any resident found to be missing a required weekly wound measurement was immediately assessed by the wound nurse, with measurements obtained and documented in the medical record. DON/designee, audited the wound tracking log and current care plans across all units to identify every resident with an active wound order. Each identified resident's medical record was cross-referenced against the required weekly wound measurement schedule to confirm measurements had been completed and documented for the required time period. Any additional residents found with missed or late wound documentation were addressed using the same process described above. The facility's wound weekly wound measurement process and policy were reviewed All licensed nursing staff will be educated on the revised wound care policy, weekly measurement requirements, correct measurement/documentation technique, and the backup coverage process. New licensed nursing staff hired orientation and annual competency validation will be updated to include weekly wound documentation requirements. DON/designee will audit 100% of active wounds weekly for four consecutive weeks to verify measurements and documentation were completed timely and accurately, then will conduct audits on a sample basis monthly for two additional months. Results of these audits will be reviewed at monthly Quality Council meetings. The QAPI Committee will determine whether continued monitoring, additional education, or further systemic changes are warranted based on audit findings. Completion Date: August 10, 2026		08/10/2026

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F0686 SS = D	Continued from page 8 pressure injury on her coccyx. A goal of healing the injury without infection was listed, and interventions included staff monitoring the area for healing, providing treatments as ordered, and updating the family or provider as needed. Further, the plan directed to review other applicable areas, such as nutrition, for their respective approaches. R1's subsequent Skin Risk Observation with Braden Scale, dated 1/19/26, identified R1 to remain at risk for pressure ulcer development along with several clinical risk factors including acute condition and cardiovascular disease. However, the evaluation now identified R1 had no current, unhealed pressure injuries. The evaluation identified the current care plan would be continued. R1's Weekly Skin Check, dated 1/20/26, identified R1 had no current alterations in skin integrity with a checkmark placed next to option reading, "None (resident's skin is clean, dry, and intact)." The form recorded there had been no changes in R1's skin since the last skin check and R1 did not have diabetes. R1's subsequent Skin Risk Observation with Braden Scale, dated 1/26/26, identified R1 had no clinical risk factors for skin breakdown with an option checked, "None of the above." The evaluation again identified R1 had no current, unhealed pressure injuries and the current care plan would be continued. R1's final Skin Risk Observation with Braden Scale, dated 2/2/26, identified R1 now had clinical risk factors present again including chronic incontinence, malnourishment and refusal of care/treatment. R1 remained at risk of pressure ulcer development with a Braden score of 16.0, and now again had a current, unhealed pressure injury on her sacral region and the current care plan would be continued. R1's Wound Management Detail Report, dated 7/27/26, identified the entered evaluations for R1's pressure injury. This identified two recorded entries which were: 1/9/26 – The pressure injury measured 1.9 X 2.0 (cm), had no drainage, no odor, no undermining and was a Stage III injury. 100% of the wound bed was covered by slough and the wound was listed as, "Stable." 1/14/26 – The pressure injury measured 1.9 X 2.0 (cm), had no drainage, no odor, no undermining and was a Stage III injury. 100% of the wound bed was			F0686			08/10/2026

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F0686 SS = D	Continued from page 9 covered by slough and the wound was listed as, “Stable.” R1’s progress note, dated 2/1/26, identified R1 developed breathing problems and was transferred to the hospital. The note lacked any recorded measurements of the pressure ulcer upon her discharge. The report lacked any further recorded evaluations of the wound including measurements, characteristics, or if the wound remained stable or not. Further, R1’s medical record was reviewed and lacked any further recorded measurements or evaluations of the pressure injury (including with characteristics) after 1/14/26 until 2/1/26, when R1 discharged the campus. Further, the record lacked clear rationale or reasoning why the ulcer was not recorded on the multiple evaluations completed (i.e., Weekly Skin Check) which recorded R1 as not having a pressure injury despite it remaining the entirety of her admission to the care center. When interviewed on 7/27/26 at 10:16 a.m., R1’s family member (FM)-A expressed multiple concerns about the care R1 received at the care center. R1 would often have to wait for long periods before getting help with mobility which caused her to not want to get into her wheelchair as she was fearful she’d then “be stuck there for hours.” The center also would not allow R1 to have side rails on the bed to help her with turning as they were considered a restraint. FM-A stated they believed R1’s pressure ulcer was just a “very small red spot” when she arrived but had worsened during her time there as when R1 arrived at the hospital (on 2/1), the wound was “huge” and “very deep.” FM-A stated there was treatment being done for it as there were multiple creams for it being placed on R1’s windowsill. FM-A questioned if they were adequately tracking it or even following the physician’s orders correctly due to the number of treatments being left in the room. When interviewed on 7/27/26 at 12:15 p.m., licensed practical nurse (LPN)-B stated if a resident had a pressure injury, then the unit manager would be notified and “most often” be the person who tracks it and records it in the chart. LPN-B stated they were not asked to do that as a floor nurse adding, “The people who are in charge of the wounds [do that].” LPN-B stated any wound measurements of evaluation would be recorded in the progress notes or on the Weekly Skin Check form. On 7/27/26 at 1:55 p.m. the director of nursing (DON) and registered nurse manager (RN)-H were			F0686			08/10/2026

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F0686 SS = D	Continued from page 10 interviewed. RN-H verified R1 had admitted with the pressure ulcer, and it remained present for the duration of her admission to the care center. RN-H was the campus wound nurse and tracked the pressure injuries using the Wound Management Detail in the record. RN-H confirmed the last time the ulcer had any recorded measurements or characteristics was on 1/14/26 and expressed they had taken some time off during the month so that is likely why it had been missed. RN-H acknowledged the repeated assessments and charting by the other staff members which recorded the lack of any pressure ulcers or skin impairments, and RN-H stated that was likely due to staff thinking they just charted items which were new and not already present. RN-H stated some education on that was being planned. RN-H explained the ADON was the “back-up” person responsible to measure and record wounds if RN-H was absent, however, it had not been done for some reason. DON reviewed the medical record and verified the lack of documentation to show a, at minimum, weekly evaluation of the ulcer with measurements and characteristics. DON stated it was important to complete the weekly evaluations on the pressure ulcer so staff could monitor it and know if it was healing or not. The facility Prevention and Treatment of Skin Breakdown policy, dated 6/2026, identified a pressure injury as a localized injury to tissue over a bony prominence which resulted from intense or prolonged pressure being applied. The policy defined a Stage III ulcer as, “Full thickness skin loss ... Slough or eschar may be visible ... Undermining or tunneling may occur.” The policy directed weekly skin audits would be performance by a nurse and skin would be observed daily with cares. The policy added, “Weekly the licensed nurse will stage, measure, and examine the wound bed and surrounding skin. If wound bed as deteriorated; notify provider.” Further added was, “Documentation reflects areas as addressed above.”			F0686			08/10/2026

Minnesota Department of Health

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/27/26, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed: H53103480C (3109360); with order cited at 0900.			20000			08/10/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

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20000	Continued from page 1 Minnesota Department of Health (MDH) documents the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.		20000			08/10/2026	
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and		20900	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. The patient discharged from the facility on 2/1/2026 and is no longer under the facility's care All residents with current active wounds were identified and immediately reviewed to confirm weekly wound measurements and assessments were		08/10/2026	

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20900	Continued from page 2 B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a stage III pressure ulcer (i.e., full-thickness skin loss) was accurately documented and adequately monitored for healing with weekly measurements and characteristic evaluations to promote continuity of care and reduce the risk of complication (i.e., worsening) for 1 of 4 residents (R1) reviewed. Findings include: R1's admission Minimum Data Set (MDS), dated 1/14/26, identified R1 had intact cognition, was not diabetic, and demonstrated no refusal of care behaviors. Further, R1 had a current stage III pressure ulcer which was present on admission, and she remained at risk of continued pressure ulcer development. R1's progress note, dated 1/8/26, identified R1 admitted to the care center and had a tube feeding present. R1 had a history of malnutrition, pain and atrial fibrillation. R1 refused a skin check. R1's progress note, dated 1/9/26, identified the nurse completed a skin inspection. R1 had a Stage III pressure injury on her coccyx with slough (dead, non-viable tissue) present in the wound bed. It measured 1.9 X 2.0 centimeters (cm) in size and was likely from friction and/or shearing as R1 spent much of her time in bed. A subsequent note, dated 1/9/26, identified R1 was incontinent of bowel and used a Foley catheter. R1's Skin Risk Observation with Braden Scale, dated 1/11/26, identified R1 to be at risk of pressure ulcer development. R1 had several risk factors including acute condition, malnourishment, and needing help to complete mobility activities such as turning side to side. The evaluation identified R1 had current, unhealed pressure injury on her sacral region along with moisture-associated skin damage (MASD) present. A new care plan would be established, and referrals were placed to dietary and therapies. R1's care plan, dated 1/12/26, identified R1 had an alteration in her skin integrity evidence by a stage III			20900	Continued from page 2 up to date and documented in accordance with physician orders and facility policy. Any resident found to be missing a required weekly wound measurement was immediately assessed by the wound nurse, with measurements obtained and documented in the medical record. DON/designee, audited the wound tracking log and current care plans across all units to identify every resident with an active wound order. Each identified resident's medical record was cross-referenced against the required weekly wound measurement schedule to confirm measurements had been completed and documented for the required time period. Any additional residents found with missed or late wound documentation were addressed using the same process described above. The facility's wound weekly wound measurement process and policy were reviewed All licensed nursing staff will be educated on the revised wound care policy, weekly measurement requirements, correct measurement/documentation technique, and the backup coverage process. New licensed nursing staff hired orientation and annual competency validation will be updated to include weekly wound documentation requirements. DON/designee will audit 100% of active wounds weekly for four consecutive weeks to verify measurements and documentation were completed timely and accurately, then will conduct audits on a sample basis monthly for two additional months. Results of these audits will be reviewed at monthly Quality Council meetings. The QAPI Committee will determine whether continued monitoring, additional education, or further systemic changes are warranted based on audit findings. Completion Date: August 10, 2026		08/10/2026

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK				STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE , NEW BRIGHTON, Minnesota, 55112			
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20900	Continued from page 3 pressure injury on her coccyx. A goal of healing the injury without infection was listed, and interventions included staff monitoring the area for healing, providing treatments as ordered, and updating the family or provider as needed. Further, the plan directed to review other applicable areas, such as nutrition, for their respective approaches. R1's subsequent Skin Risk Observation with Braden Scale, dated 1/19/26, identified R1 to remain at risk for pressure ulcer development along with several clinical risk factors including acute condition and cardiovascular disease. However, the evaluation now identified R1 had no current, unhealed pressure injuries. The evaluation identified the current care plan would be continued. R1's Weekly Skin Check, dated 1/20/26, identified R1 had no current alterations in skin integrity with a checkmark placed next to option reading, "None (resident's skin is clean, dry, and intact)." The form recorded there had been no changes in R1's skin since the last skin check and R1 did not have diabetes. R1's subsequent Skin Risk Observation with Braden Scale, dated 1/26/26, identified R1 had no clinical risk factors for skin breakdown with an option checked, "None of the above." The evaluation again identified R1 had no current, unhealed pressure injuries and the current care plan would be continued. R1's final Skin Risk Observation with Braden Scale, dated 2/2/26, identified R1 now had clinical risk factors present again including chronic incontinence, malnourishment and refusal of care/treatment. R1 remained at risk of pressure ulcer development with a Braden score of 16.0, and now again had a current, unhealed pressure injury on her sacral region and the current care plan would be continued. R1's Wound Management Detail Report, dated 7/27/26, identified the entered evaluations for R1's pressure injury. This identified two recorded entries which were: 1/9/26 – The pressure injury measured 1.9 X 2.0 (cm), had no drainage, no odor, no undermining and was a Stage III injury. 100% of the wound bed was covered by slough and the wound was listed as, "Stable." 1/14/26 – The pressure injury measured 1.9 X 2.0 (cm), had no drainage, no odor, no undermining and was a Stage III injury. 100% of the wound bed was			20900			08/10/2026

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20900	Continued from page 4 covered by slough and the wound was listed as, “Stable.” R1’s progress note, dated 2/1/26, identified R1 developed breathing problems and was transferred to the hospital. The note lacked any recorded measurements of the pressure ulcer upon her discharge. The report lacked any further recorded evaluations of the wound including measurements, characteristics, or if the wound remained stable or not. Further, R1’s medical record was reviewed and lacked any further recorded measurements or evaluations of the pressure injury (including with characteristics) after 1/14/26 until 2/1/26, when R1 discharged the campus. Further, the record lacked clear rationale or reasoning why the ulcer was not recorded on the multiple evaluations completed (i.e., Weekly Skin Check) which recorded R1 as not having a pressure injury despite it remaining the entirety of her admission to the care center. When interviewed on 7/27/26 at 10:16 a.m., R1’s family member (FM)-A expressed multiple concerns about the care R1 received at the care center. R1 would often have to wait for long periods before getting help with mobility which caused her to not want to get into her wheelchair as she was fearful she’d then “be stuck there for hours.” The center also would not allow R1 to have side rails on the bed to help her with turning as they were considered a restraint. FM-A stated they believed R1’s pressure ulcer was just a “very small red spot” when she arrived but had worsened during her time there as when R1 arrived at the hospital (on 2/1), the wound was “huge” and “very deep.” FM-A stated there was treatment being done for it as there were multiple creams for it being placed on R1’s windowsill. FM-A questioned if they were adequately tracking it or even following the physician’s orders correctly due to the number of treatments being left in the room. When interviewed on 7/27/26 at 12:15 p.m., licensed practical nurse (LPN)-B stated if a resident had a pressure injury, then the unit manager would be notified and “most often” be the person who tracks it and records it in the chart. LPN-B stated they were not asked to do that as a floor nurse adding, “The people who are in charge of the wounds [do that].” LPN-B stated any wound measurements of evaluation would be recorded in the progress notes or on the Weekly Skin Check form. On 7/27/26 at 1:55 p.m. the director of nursing (DON) and registered nurse manager (RN)-H were		20900			08/10/2026	

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20900	Continued from page 5 interviewed. RN-H verified R1 had admitted with the pressure ulcer, and it remained present for the duration of her admission to the care center. RN-H was the campus wound nurse and tracked the pressure injuries using the Wound Management Detail in the record. RN-H confirmed the last time the ulcer had any recorded measurements or characteristics was on 1/14/26 and expressed they had taken some time off during the month so that is likely why it had been missed. RN-H acknowledged the repeated assessments and charting by the other staff members which recorded the lack of any pressure ulcers or skin impairments, and RN-H stated that was likely due to staff thinking they just charted items which were new and not already present. RN-H stated some education on that was being planned. RN-H explained the ADON was the “back-up” person responsible to measure and record wounds if RN-H was absent, however, it had not been done for some reason. DON reviewed the medical record and verified the lack of documentation to show a, at minimum, weekly evaluation of the ulcer with measurements and characteristics. DON stated it was important to complete the weekly evaluations on the pressure ulcer so staff could monitor it and know if it was healing or not. The facility Prevention and Treatment of Skin Breakdown policy, dated 6/2026, identified a pressure injury as a localized injury to tissue over a bony prominence which resulted from intense or prolonged pressure being applied. The policy defined a Stage III ulcer as, “Full thickness skin loss ... Slough or eschar may be visible ... Undermining or tunneling may occur.” The policy directed weekly skin audits would be performance by a nurse and skin would be observed daily with cares. The policy added, “Weekly the licensed nurse will stage, measure, and examine the wound bed and surrounding skin. If wound bed as deteriorated; notify provider.” Further added was, “Documentation reflects areas as addressed above.” SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on pressure ulcer monitoring and evaluation; then educate staff on those policy' expectations and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 Days			20900			08/10/2026