



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 17, 2026

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

RE: CCN: 245310

Cycle Start Date: August 20, 2026

Dear Administrator:

On September 3, 2026, we notified you a remedy was imposed. On September 17, 2026, the Minnesota Departments of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 14, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 18, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 3, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 18, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 14, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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



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September 17, 2026

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

Re: Reinspection Results
Event ID: 341D7E-H2

Dear Administrator:

On September 17, 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 August 20, 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



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September 3, 2026

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

RE: CCN: 245310

Cycle Start Date: August 20, 2026

Dear Administrator:

On August 20, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 18, 2026

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 18, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 18, 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 18, 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 18, 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)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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

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 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 location and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 20, 2027 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 Tamika Brown at (312) 353-1502. 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
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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September 3, 2026

Administrator

BENEDICTINE HEALTH CENTER INNSBRUCK

1101 BLACK OAK DRIVE

NEW BRIGHTON, MN 55112

Re: State Nursing Home Licensing Orders

Event ID: 341D7E-H1

Dear Administrator:

The above facility survey was completed on August 20, 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 08/20/2026	
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 8/19/26 to 8/20/26, 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 complaints were reviewed: H53103762C (3159966), H53103693C (3153950); with non-compliance cited at F684 and F686. Additionally, an incidental finding of non-compliance was cited at F641. 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			09/14/2026
F0686 SS = G	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 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote			F0686	This plan of correction constitutes the facility's credible allegation of compliance. 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. R2 The resident was discharged from the facility on 08/03/2026. A list of residents admitted to the facility during the last week of will be audited to confirm that orders requiring clarification were clarified immediately. A list of all residents currently using recliners for		09/14/2026

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
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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 08/20/2026	
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
F0686 SS = G	Continued from page 1 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 comprehensively assess and implement an effective turning and repositioning program to prevent pressure ulcer development; failed to ensure the care plan was updated with new interventions to ensure implementation; and failed to ensure a developed pressure ulcer was accurately tracked and monitored in the medical record for 1 of 3 residents (R2) reviewed for pressure ulcer care. R2 needed physical assistance with repositioning, however, no consistent repositioning program was implemented and R2’s care plan was not updated as she became more at risk for pressure ulcer development. R2 then developed multiple, avoidable stage II pressure injuries on her coccyx which constituted actual harm. Findings include: The Centers for Medicare and Medicaid (CMS) State Operations Manual (SOM), Appendix PP – Guidance to Surveyors for Long Term Care Facilities, dated 7/23/2025, identified the current regulatory expectations for pressure ulcer care. This defined an avoidable pressure ulcer as, “... means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident’s clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.” Further, the SOM defined stage II pressure injury as a partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed would be viable, pink or red, moist, and may also appear as an intact blister. A Vulnerable Adult Maltreatment Report (MAARC), dated 8/10/26, identified concerns about R2’s care while at the care center. The report alleged R2 had been admitted to the center in late June 2026 and discharged back to her assisted living facility (ALF) on 8/3/26; however, R2 now had multiple pressure sores which had not been present prior. R2’s Clinical Documentation (Admission), dated 6/29/26, identified R2 admitted to the care center and had intact long-term and short-term memory but with some difficulty making decisions about care			F0686	Continued from page 1 bed in their rooms will be identified and turn and repositioning measures are in place and the care plan updated. A list of all residents identified as at-risk for skin breakdown per the Braden Scale will be run. An audit of each of these residents' care plans will be completed to ensure a toileting care plan and, for residents who are dependent, a repositioning plan are in place. All dependent residents identified as at-risk (and not dependent for mobility) will be reviewed to ensure Point of Care (POC) charting is in place to capture repositioning and skin-related interventions. Re-education for all nursing staff was immediately completed on the required steps per policy and steps to be taken when wounds are identified A process will be established with the Nurse Practitioner to ensure the CM/DON can review their clinical notes for any follow up requirements The DON/designee will audit three residents per week to verify pressure-relief cushions are in place and in use in recliners, and that this intervention is reflected on the care plan. Audits will occur for 6 weeks and will be reviewed by the QAPI committee. The DON/designee will audit the care plans of at-risk (Braden Scale) residents weekly to confirm toileting and repositioning interventions are in place and being carried out, with ongoing auditing built into the facility's regular QA process. Results of all audits above will be reported to and reviewed by the QAPI committee to ensure the deficient practice does not recur.		09/14/2026

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 08/20/2026	
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
F0686 SS = G	Continued from page 2 in new settings. R2 had occasional bowel and bladder incontinence and occasional pain recorded. R2’s initial Skin Risk Observation with Braden Scale, dated 6/29/26, identified R2 had clinical risk factors for skin breakdown including an acute condition and diabetes. R2 needed partial/moderate assistance with sitting-to-lying and vice versa. R2 used a brace/splint device (on her leg) and had no current, unhealed pressure injuries or other skin problems (i.e., diabetic ulcers, infections, moisture-associated skin damage [MASD]). R2 demonstrated no nutritional concerns (i.e., cachexia, edema, decreased output) and scored a 19.00 on her Braden Scale (tool used to help predict pressure injury development risk) which recorded her as, “Not at Risk.” A section labeled, “Interventions,” recorded specific interventions staff could implement with a checkmark being placed next to them. This recorded that no measures were taken (such as a blanket cradle, trapeze) but R2 was on a turning and repositioning program and on nutritional/hydration interventions to help manage skin problems. The evaluation concluded with, “Continue Current Care Plan,” and with referrals placed to physical and occupational therapy (PT/OT). R2’s Weekly Skin Check, dated 7/2/26, identified a shower was provided and R2 had no current skin issues. R2’s admission Minimum Data Set (MDS), dated 7/5/26, identified R2 had moderate cognitive impairment and demonstrated no rejection of care behavior. R2 had multiple medical conditions including diabetes mellitus, high blood pressure, and a bone fracture. R2 needed partial/moderate assistance with rolling in bed side-to-side, going from lying to sitting, and transferring from her bed to a chair. Further, R2 had no current, unhealed pressure injuries, she was determined as not at risk for developing them, was given a pressure reducing device for her chair and bed but was not on a turning and repositioning program. R2's corresponding Pressure Ulcer/Injury Care Area Assessment (CAA), dated 7/8/26, identified the CAA triggered due to R2 needing assistance with cares, urinary status and Braden Scale score. The CAA listed, "partial/moderate for all bed mobility." The CAA then added, "Resident Braden scale sore: 19, not at risk." R2 had no current pressure injuries but "is at risk for skin breakdown." R2 received PT/OT and a care plan to minimize risks would be developed. R2’s next Skin Risk Observation with Braden Scale,			F0686			09/14/2026

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 08/20/2026	
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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F0686 SS = G	Continued from page 3 dated 7/11/26, identified R2 continued to have some clinical risk factors present and remained occasionally incontinent of bowel. R2 continued to use a brace/splint and now the evaluation marked, "Limited Mobility/Bedfast." R2 had no current, unhealed pressure injuries or other skin problems. However, R2's Braden Scale score had now decreased and she was labeled, "At Risk." The section labeled, "Interventions," now only recorded a single intervention which was a pressure reducing device for her chair. The evaluation concluded with, "Continue Current Care Plan." R2's Weekly Skin Check, dated 7/14/26, identified R2 had a shower provided and had no current skin issues. R2's next Skin Risk Observation with Braden Scale, dated 7/19/26, identified R2 continued to have some clinical risk factors, such as cardiovascular disease, and still needed partial/moderate help to turn left-to-right in bed and now needed substantial/maximal assistance with going from lying to sitting. R2 remained occasionally incontinent of bowel and no longer was using a brace/splint device as it was left unchecked. R2 continued to have no current, unhealed pressure injuries or other skin problems. However, R2's Braden Scale score had decreased further (more at risk with the lower the score), and she continued to be labeled, "At Risk." The section labeled, "Interventions," now had no interventions or measures checked or recorded and the evaluation concluded, "Continue Current Care Plan." R2's care plan, last reviewed 7/14/26, identified R2 had an ADL self-care deficit and needed assistance of one for toileting. The plan recorded, "Resident can verbally ask for assistance and is occasionally incontinent of bowel and bladder," adding further, "Resident has a bowel and bladder plan that will help them remain free of skin breakdown ..." However, the plan lacked further details on the exact plan or timing with which R2 would be helped/offered/assisted with toileting. R2's skin care plan, dated 6/30/26, identified R2 was at risk for an alteration in skin integrity due to diabetes, decreased mobility and impaired circulation. The plan listed a goal which read, "The resident will not develop further skin alterations." A single intervention was listed on the care plan which read, "Resident has the following skin protective measures in place: (Special Mattress, barrier cream applied to dry areas as needed)." The date of this intervention was listed as 6/30/26. The care plan lacked any further interventions, such as a turning			F0686			09/14/2026

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 08/20/2026	
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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F0686 SS = G	Continued from page 4 and repositioning program, to help address R2's skin risk despite her having decreasing Braden Scale score(s), being recorded as at-risk for pressure injuries on her evaluations and having impaired mobility. R2's progress note, dated 7/24/26, identified an "open area" was now found on R2's inner buttocks. It showed redness and some minimal swelling. The note recorded, "Continuing to use cream for skin tears and between buttocks." The note lacked any recorded measurements of the identified areas or other characteristics of the developed wound; nor evidence of what, if any, ongoing interventions the nurse placed to help promote healing of the wound. Registered nurse (RN)-B authored the note. R2's last completed Skin Risk Observation with Braden Scale, dated 7/25/26, identified R2 had diabetes mellitus, continued to need physical assistance with most mobility tasks, and continued to have bowel incontinence. The evaluation recorded R2 had no current, unhealed pressure injuries or other skin problems and listed a Braden Scale score which now showed R2 was not at risk for pressure injury development (despite the progress note on 7/24 showing an open area). The section labeled, "Interventions," identified the staff would elevate her edematous extremities but no other interventions, including turning and repositioning program, were marked despite an open area developing the day prior. The evaluation concluded with, "Continue Current Care Plan." R2's M Health Fairview Geriatrics note, dated 7/28/26, was authored by the nurse practitioner (NP)-A and recorded R2 as being seen for an episodic care visit. The note now added a concern which read, "4. Pressure ulcer of coccygeal region, stage 2 (H)." The note continued, "Patient seen for follow up ... now PU [pressure injury] coccyx in cleft 2 X 0.5 cm [centimeters] plus R medial buttock 1 cm area and L buttock 1.2 cm area both excoriated and open, no discharge." The note listed a section labeled, "Assessment/Plan," which reiterated the pressure injuries on the coccyx with dictation reading, "... coccyx plus bilateral buttocks open areas with maceration/excoriation." NP-A directed to start barrier cream twice daily, have the wound nurse evaluate the area that week, and offload as possible. R2's Weekly Skin Check, dated 8/1/26, identified R2 was given a shower and recorded a skin issue as, "Other type of alteration." The form outlined R2 as having "excoriation and two open areas noted to			F0686			09/14/2026

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F0686 SS = G	Continued from page 5 coccyx area.” The completed form lacked any written dictation of what, if any, interventions were done for the area or further wound characteristics (i.e., measurements, odor, drainage). R2’s progress note, dated 8/4/26 (late entry for 7/28/26), identified the campus wound nurse (RN)-A had attempted to see R2 but she was not in her room. A subsequent note, dated 8/4/26 (late entry for 7/29/26), identified RN-A again attempted to see R2 but she was going to a medical appointment but R2 was seen by the nurse practitioner who had placed orders for the developed wound. These notes lacked evidence of any reapproach of R2 or what, if any, actions RN-A had given to other nurses for evaluating the wound or placing new interventions for it since they had been unable to do so. R2’s Treatment Administration History (TAR), dated 7/2026, identified R2’s recorded treatments with staff initials and date/time of them to show what was completed. This listed an intervention to apply barrier cream to the developed pressure ulcer twice daily with a start date recorded, “07/28/2026 – 08/03/2026 (DC Date).” This was first recorded as completed on the evening medication pass on 7/28/26. The TAR lacked any interventions for offloading or barrier cream prior to 7/28/26 despite R2 needing assistance with mobility, having incontinence, and developing the pressure injury on 7/24/26 (four days prior). R2’s Wound Management details, located within the medical record, identified R2 had multiple bruises which were identified upon admission. However, it lacked evidence that the developed pressure ulcers (first identified on 7/24) were added or tracked in this detail report until 8/3/26 when R3 discharged the care center back to her ALF. On 8/20/26 at 8:34 a.m., a telephone call was placed to R2’s family member (FM)-D to discuss R2’s care while at the care center. However, they were not reached. When interviewed on 8/20/26 at 8:40 a.m., NA-A stated care plans were communicated to the floor staff and directed how to transfer a resident and if they were on a repositioning program or not. NA-A stated all residents were on a “check on them” program every few hours. If someone was helped with toileting or repositioning, then it should be recorded in the POC charting each time the care was provided adding, “Every time you go in the room [record it].” NA-A stated they vaguely remembered working with R2 and recalled applying barrier cream			F0686			09/14/2026

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F0686 SS = G	Continued from page 6 to R2’s coccyx and bottom and believed it was something being done the entire time R2 had been admitted to the care center. R2 did not have any skin issues or wounds to NA-A’s recall. When interviewed on 8/20/26 at 8:56 a.m., NA-B stated a resident on a repositioning program would be identified on the care plan which was then placed in a folder for staff to review each day to be aware of that. The staff just tracked the repositioning themselves using a pen and paper and whether that information was charted in the POC data would be “a great question for the nurses.” NA-B recalled there, at times, being a question about it on the POC to answer but it was rather just a single “yes or no” question about if you did it or not. NA-B stated they thought the nurses charted more specific interventions for pressure ulcer prevention in their records. NA-B recalled working with R2 when she was at the care center and described R2 as needing assist of one with transfers and most tasks except eating. R2 was also incontinent of bowel and bladder. R2 was not on a repositioning or toileting program but rather only “just when she would ask [for help],” adding R2 didn’t like to lay in her bed much but rather spent a lot of time in her recliner chair. The staff would, if R2 asked for it, place R2’s wheelchair cushion in the recliner, too. NA-B recalled working on 7/24/26 when they saw R2’s coccyx and the wounds for the first time. They appeared “a little red” and like “a little open wound.” NA-B notified the nurse about it, who told them to apply barrier cream on it which had already been present in the room. NA-B stated they were unsure where or how long staff had been applying barrier cream to R2’s coccyx prior to the wound development. NA-B reiterated R2 had not been on a turning and repositioning program prior to or following the wound developing to their recall. R2’s Point of Care (POC) History report, dated 7/17/26 to 8/4/26, identified the care recorded by the nursing assistant (NA) staff members for the period. R2 had no recorded behaviors and had multiple episodes of bladder and bowel incontinence. R2’s ability to go from sitting-to-lying and vice versa was recorded mostly as, “Substantial/maximal assistance,” with some, “Dependent.” The complete POC documentation lacked evidence that R2 was placed on a repositioning program or having any consistent turning and repositioning completed for the period. R2’s medical record was reviewed and lacked evidence R2 had been started on a consistent turning and repositioning program to help prevent			F0686			09/14/2026

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F0686 SS = G	Continued from page 7 pressure ulcer development despite needing physical assistance with transfers and bed mobility; lacked evidence R2’s skin ability to tolerate prolonged periods of pressure (i.e., tissue tolerance) had ever been considered or evaluated in the recliner chair since she spent much of her time there; lacked evidence the pressure ulcers were comprehensively assessed when they developed to determine what interventions were needed to promote healing and prevent continued decline; and lacked evidence of a consistent treatment being implemented until 7/28/26 which was four days after the area was first charted. Further, the record lacked evidence R2’s skin care plan was ever adjusted with new interventions despite a worsening Braden Scare being charted. R2 then developed three stage II pressure ulcers as diagnosed by the provider. When interviewed on 8/20/26 at 9:42 a.m., RN-B explained if a new skin impairment, including a pressure injury, was identified then the nurse who first saw it was supposed to assess it and then update the wound nurse (RN-A) or the unit manager about it. The wound should also be measured and all the actions taken should be recorded in the progress notes. The wound nurse would then evaluate the wound, and they would stage it, if needed, and make further treatment recommendations and communicate with the physician. RN-B stated the Weekly Skin Check forms were to be completed on the scheduled bath day for the resident and should include both current and new skin impairments but if the wound had already been assessed, then staff would just recorded any changes to it on that form and not go into full detail about it. RN-B stated the floor nurses also complete the Skin Risk Observation/Braden forms and should place checkmarks next to the interventions they have orders to do for the person but just because there were no orders for someone to be repositioned, the nurses and aides could still do that adding, “I feel like that is common sense.” RN-B stated there had been some training on how to complete those skin forms when they started working at the care center a few months prior, but not “down to the detail” of exactly what check-marking the items meant or who then updates the care plan with those marked interventions. RN-B stated they felt the unit manager would be the person who updated the care plan with interventions as the floor staff more just identified the wound and then the unit manager would take over the care and care plan adjustments moving forward adding, “We [floor nurses] don’t do any changes to the care plan unless we’re told to.” RN-B recalled working with R2 and described her as “pretty immobile” and often			F0686			09/14/2026

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F0686 SS = G	Continued from page 8 sleeping in her recliner chair instead of her bed. There was rarely, if ever, a cushion used in the recliner seat to RN-B’s recall but sometimes R2 would ask for a pillow on her side due to hip pain. R2 was “pretty incontinent” of bowel and bladder but did void in the toilet at times when assisted there. RN-B recalled the wound they saw on R2’s bottom area on 7/24/26 and described it as “red” but with intact skin looking like “two pennies next to each other.” There were multiple areas present and the aide mentioned there was some barrier cream in the bathroom, so RN-B told the aide to just apply that. R2 reported the area was “a little painful” too. RN-B then updated the nurse they were working with that day for orientation about the wound but was unable to recall the nurse’s name. RN-B stated they did not update the wound nurse about the wound as, at that time, they did not know who it was even; and they were unsure if the nurse they reported it to did either, rather the nurse they reported it to just said to apply the barrier cream and “keep an eye on it.” RN-B stated they could not recall if R2 was on a turn and reposition program or not but did recall seeing her often slide down in her wheelchair and having a slumped appearance, so staff would have to boost her back up often. RN-B stated they were unsure how the NA staff members chart repositioning if someone was on a repositioning program adding, “I have never seen their charting.” RN-B then stated they thought someone on a repositioning or offloading program would show up on the TAR with an intervention for the nurses to record. The nurses could also write it in a progress note, but nobody had ever directed them to do that, rather it was just to get the information into the medical record. RN-B verified R2 was “pretty healthy” and eating well during their stay at the care center. R2 was not considered in terminal condition, either. Further, RN-B stated they were unsure who or how often someone evaluates the skin tolerance to pressure (i.e., tissue tolerance) and did not know if occupational therapy (OT) had ever been involved with R2’s skin interventions or not. When interviewed on 8/20/26 at 10:48 a.m., occupational therapist (OT)-A recalled working with R2 and reviewed her medical record. R2 had “waxing and waning” cognition and family had been considering memory care options at the end of her admission. R2 had a foot injury and wore a CAM boot due to fractures going from weight-bearing as tolerated (WBAT) to toe-touch weight bearing (TTWB) mid-stay after an orthopedics appointment. OT-A recalled R2 struggled at times to use the call light system as it was different than the style she had			F0686			09/14/2026

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F0686 SS = G	Continued from page 9 been using at her ALF. Upon admission, OT-A stated R2 needed moderate to maximum assistance with repositioning then progressed to needing more minimal to moderate assistance towards the end of her stay. OT-A stated they did not think R2 would know to reposition herself independently without cues or help and needed physical help to do that throughout her admission. OT-A stated they did not think R2 had ever been on a repositioning program and could not recall nursing staff ever reaching out to them (OT) about her spending a lot of time in her recliner chair. OT-A stated use of a recliner chair instead of a bed was “something I want to look into more” as it did not provide the same “offloading pressure” as a mattress would have. The OT could even then do a “pressure-mapping” on R2 to help determine more interventions to relieve pressure in the wheelchair or recliner. OT-A recalled doing a “seat dumping” on R2’s wheelchair but that was more for her sliding and her falling. OT-A stated they were unaware R2 had developed pressure ulcers at the care center. On 8/20/26 at 11:29 a.m., a group interview was held with the director of nursing (DON), RN-A, nurse manager (RN)-D, and the regional director of clinical services (RDCS). RN-D explained that when a resident was admitted to the care center, a skin check was completed and recorded. If wounds existed, then they would be recorded in the Wound Management section and tracked, and RN-A would be updated about them. If there is no skin issue present upon admission, then a Braden Scale is completed and, depending on that result, they are placed on a repositioning program if they are at risk. The Braden Scale is then repeated weekly for four weeks by the floor nurses. The care plan “normally” was then updated by the manager if the person was at risk for skin breakdown. RN-A stated the floor nurses were also able to update the care plan with a reposition program and consult with other resources, such as the dietitian, if they determined they needed to do so about skin risk or wounds. DON explained they no longer have tissue tolerance review as part of their assessment process as the weekly skin checks and daily general observations of skin with care replaced it. RN-A stated if a resident was using a device frequently, like a recliner, then they could visit with OT and have them review it and provide a cushion for it, if needed, but the resident would still likely need to be offloaded by the staff. RN-D verified R2 needed physical help to reposition, and the care plan should be updated with interventions as the Skin Risk/Braden evaluations are completed. The timeline of events with R2’s wound was reviewed. RN-D recalled seeing the progress note			F0686			09/14/2026

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F0686 SS = G	Continued from page 10 (dated 7/24) about the wound concern and updated the provider about it who saw it then (on 7/28) and ordered barrier cream for it. The provider only told them it was “some excoriation but nothing major” and never used the term ‘pressure injury’ which would have caused them to have a hastier response to it. RN-A and RN-D stated they both attempted to evaluate the wound between 7/24 and 7/28 but had been unable to connect with R2 which is why the notes were entered into the system late (after R2 discharged). RN-A verified the floor nurses could also have fully assessed the wound and started treatments on it since they were unable to see it. RN-D verified the medical record lacked a re-assessment of the wound after it developed or revisions to the care plan and stated they never updated the care plan after the wounds developed as they wanted to evaluate the wound first before adding them to the care plan. RN-D also acknowledged that the care plan lacked any further interventions for skin risk other than the initial single intervention loaded despite the worsening Braden Scale scores being recorded. DON stated that if a resident was on a reposition program, the NA staff should be recording that in the POC charting or the nurses could record it on the TAR. However, R2 did not have this charting in her record and had not been placed on a reposition program per the care plan, either. DON stated the first time they had learned about R2 developing multiple pressure injuries was after R2 discharged and her ALF reached out asking about the wounds. When asked if R2 would have still developed the pressure injuries if all these actions, such as being placed on a repositioning program and having new care plan interventions added as her Braden Scale score worsened, had been taken, RN-D stated they didn’t think R2 needed much help to reposition at the beginning of her admission and felt the nurses were checking on her routinely. DON stated they would keep looking for more information in the medical record to show what, if any, additional actions or interventions were being done and provide them if located. No further information was received. When interviewed on 8/19/26 at 1:49 p.m., NP-A stated they were the primary medical provider to R2 while she had been at the care center. NP-A stated they were first notified about the developed skin impairment for R2 on 7/28/26 which they went and evaluated. There were three areas total and each was a stage II pressure ulcer. The areas appeared, “red and raw” but had no depth or slough present rather just, “raw, macerated areas.” NP-A stated if a			F0686			09/14/2026

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F0686 SS = G	Continued from page 11 wound developed between care visits, then the unit manager could call and update them about it. NP-A stated the charting on 7/24/26 from the nurse wasn't maybe enough to warrant an update to the provider alone as some nurses are newer or more raw than others. NP-A stated the wound nurse should have been made aware when the skin was first seen, and they could have evaluated the wound and then contacted the provider for input if needed adding, "That should have happened." The facility Prevention and Treatment of Skin Breakdown policy, dated 6/2026, identified residents were assessed upon admission and weekly thereafter for four weeks using the Skin Risk Assessment. The policy recorded, "Those residents at an increased risk for impaired skin integrity are provided preventative measures to reduce the potential for skin breakdown." The policy outlined a care plan would be implemented and updated for skin risk interventions based on areas of risk, resident assessment, a Braden of 15 or less, and resident preferences. Resident's skin was observed daily with cares and concerns would be reported to the nurse; a therapy consult would be placed as appropriate. If a new pressure injury was identified after admission, the policy directed to document it in the medical record, initiate standing orders for wound care, notify the provider and resident representative, notify the supervisor (manager) and evaluate current pressure reduction interventions and revise the care plan. The documentation should reflect these actions completed.			F0686			09/14/2026
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 ensure physician orders for a heart monitor were acted upon and implemented as soon as possible to help prevent complication (i.e., arrythmia, cardiac arrest) for 1 of 1 resident (R1) reviewed who			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. R1 heart monitor order was clarified with the attending provider and the device was placed on the resident as ordered. R1 chart was reviewed to confirm the heart monitor order, clarification, and application were accurately documented, and the interdisciplinary team was notified of the corrected order. A list of residents admitted to the facility during the last week of will be audited to confirm that orders requiring clarification were clarified immediately.		09/14/2026

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F0684 SS = D	Continued from page 12 needed a heart monitor. R1 had orders upon admission to the care center to implement a remote cardiac monitor; however, this device was not obtained and/or started until 7/31/26 (8 days later) despite R1 having a history a bradycardia (slow heartbeat) and prior heart blocks (a delay or stoppage of the electrical signals that travel in the heart). Findings include: On 8/19/26 at 8:47 a.m., R1's family member (FM)-B was interviewed and expressed several concerns about the care provided to R1 while he was at the care center. R1 had discharged from the hospital to the care center with orders for a "remote cardio monitor" to be worn. The hospital reported that it had been ordered and sent to the care center; however, there was an unnecessary delay in getting it attached to R1 for some reason at the care center. FM-B finally asked a nurse about it and why it had not been attached to R1 yet, and the nurse responded they didn't know how to attach it and doing so was "past our capabilities of nursing." FM-B stated this was unacceptable and concerning. R1's (Hospital) After Visit Summary (AVS), dated 7/23/26, identified R1 had been in the hospital for bradycardia (slow heartbeat) and listed orders to be done at the care center. A section labeled, "Other Diagnostics," identified an order for ECG Ambulatory Real Time Cardiac Monitoring which would be mailed to the home for hook-up. R1 was to wear the monitor for 14 days. These orders were circled with handwritten circles and had handwritten dictation reading, "Clarify ECG monitoring to be done here or post-DC?" The handwritten items did not have any initials or signatures to show who did them. R1's subsequent M Health Fairview Geriatrics (Note), dated 7/24/26, identified R1 had been seen by the onsite nurse practitioner (NP)-A and evaluated. R1 had been in the hospital for multiple reasons which included bradycardia with Mobitz 1 and Mobitz 2 AV blocks. R2 was recorded on the examination as oriented, in no distress and ambulating despite being non-weight bearing (NWB). The note recorded, "... not on cardiac monitor as thought [sic] indicated by hospital ...". The note included a review of R2's heart failure and directed, "– contact Mayo cardiology for cardiac monitor." R1's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 7/2026, identified all R1's completed treatments.			F0684	Continued from page 12 The facility will revise the Order clarification process so that any order requiring clarification is routed directly to a licensed nurse for telephone or electronic clarification with the attending provider, rather than being placed in the provider's folder to await the next visit. Facility will Reeducation to all HUC staff and licensed nurses will be provided on the revised order clarification process, including the requirement to notify nursing staff immediately when an order needs clarification. Facility will Reeducation to licensed nursing staff on their responsibility to follow up on and apply clarified orders in a timely manner once clarification is obtained. The DON/designee will review the HUC job description and workflow expectations and update them as needed to reflect the revised order clarification process. The DON or designee will audit five admissions per week to verify that any order requiring clarification was acted on immediately by nursing staff. Audits will occur for 4 weeks and will be reviewed by the QAPI committee. Results of all audits above will be reported to and reviewed by the QAPI committee to ensure the deficient practice does not recur.		09/14/2026

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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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F0684 SS = D	Continued from page 13 This included: - “Heart monitor should be charged. Check in the telephone for percentage. Remove when going to shower,” scheduled every shift. This had a start date recorded, “07/31/2026 – 08/03/2026.” This was first signed off as completed on 7/31/26 in the morning shift. R1’s MAR and TAR, dated 8/2026, identified R1’s completed treatments for the month. This included: - “MoMe Device [heart monitor]: Ask patient if he has received any phone calls from monitoring clinic. If so, assess [patient] and follow guidance ...,” scheduled every shift. This had a start date recorded, “08/03/2026 – 08/13/2026.” This was first signed off as completed on 8/3/26 in the morning shift. - “MoMe Heart Monitor ... ensure placement each shift ...” This had a start date recorded, “08/03/2026 to 08/13/26.” This was first signed off as completed on 8/3/26 in the morning shift. Both the MAR and TARs (dated 7/2026, 8/2026) lacked any recorded interventions for the device until 7/31/26 (eight days after R1 admitted). R1’s progress notes, dated 7/23/26 to 8/13/26, identified the following: On 7/23/26, R1 was admitted from the hospital and was alert and oriented. On 7/31/26, the heart monitor was connected to R1 and R1 had been shown how to record symptoms (i.e., chest pain, racing heartbeat) on it. Registered nurse (RN)-C authored the note. On 8/4/26, staff received a call from the heart monitor device clinic with concerns for “serious heart rhythms from the heart monitor.” R1 denied any symptoms when asked and the onsite provider evaluated him. When interviewed on 8/19/26 at 11:43 a.m., RN-C recalled working with R1 and explained when someone admitted with orders for a device then the health unit coordinators (HUC) would place those orders and address them; however, RN-C stated they were unsure if that applied to heart monitors or not before adding, “I’m assuming it would also be [them].” RN-C then expressed, “I am not 100% sure of the whole process.” RN-C stated the floor nurse would just be responsible for applying the device			F0684			09/14/2026

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F0684 SS = D	Continued from page 14 when it arrived at the room. RN-C recalled having to apply R1’s device to him on 7/31/26 and was not comfortable with doing that, so they asked the director of nursing (DON) for assistance. RN-C stated they were not sure why it took eight days to finally get it attached and connected to R1. RN-C stated they recalled R1’s family member handing them the box with the device in it on 7/31/26 and asking why it had not been started yet adding, “I had no idea what [they] were talking about.” RN-C stated the box had the heart monitor inside and RN-C had seen that same box sitting in R1’s room a few days prior when they worked but never opened it or asked about it. RN-C reiterated the box they saw sitting in the room was the same box the family handed them on 7/31/26. When interviewed on 8/19/26 at 12:14 p.m., HUC-D explained cardiac monitors were sometimes sent with the patient from the hospital to the care center, or at times, the family would bring them in. The orders are still entered into the system by the HUC but getting the device was done by the unit manager or someone else. HUC-D reviewed R1’s AVS and verified it was their handwriting on the document around the cardiac monitor. HUC-D wrote that and placed it into the providers mailbox to be addressed. HUC-D stated that was the last time they addressed it and were unsure when or if the device ever arrived at the care center. HUC-D stated they usually do not hear about the resolutions the providers end up making with things like that. R2’s medical record was reviewed and lacked evidence of when the cardiac monitor arrived at the care center or what, if any, actions were made to secure the device by the staff. The record lacked evidence or rationale of why the device was not received and immediately attached to R1 despite the box with the device being seen by staff in his room days prior to the family having to question it to them. On 8/19/26 at 12:25 p.m., the DON and unit manager (RN)-H were interviewed. RN-H stated there were multiple cardiac monitors used at times and didn’t think there were orders for it upon admission for R1. RN-H was shown the AVS (which directed to use it) and stated the lack of access to that hospital’s EPIC chart maybe contributed to the delay in getting it as the order did not come to them (RN-H). The nurses were supposed to check orders once entered on the MAR/TAR, but the heart monitor didn’t have “that trigger” maybe, either. A care conference was held for R1 and the family expressed concerns with it then, which the family			F0684			09/14/2026

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F0684 SS = D	Continued from page 15 then called and got a device sent over. The family had “got to us” before the staff acted on the order. DON stated he was first told of the device order on 7/31/26 when asked to help apply it by the nurse. RN-H stated the order for it should have been entered into Matrix (the care center system) while awaiting clarification but that did not happen, so the communication for clarification never made it to the manager to be followed-up on. RN-H stated it was important to ensure orders for cardiac monitoring were implemented as soon as possible so cardiac events can be tracked and logged. RN-H reiterated they should have likely checked “the whole AVS” and not just the Matrix orders, and the DON added that maybe since the HUC was newer “that process slipped.” At 1:31 p.m., RN-H returned and stated they had investigated the situation more and the HUC sent the clarifications to the provider (addressed on 7/24) but it was “not communicated with us right away.” The provider did not write a physical order to follow up on the cardiac monitor just mentioned it in his note so that likely contributed to a delay in getting the device. A facility policy on cardiac monitors was requested; however, none was received.			F0684			09/14/2026
F0641 SS = A	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-			F0641			09/14/2026

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F0641 SS = A	Continued from page 16 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the discharge tracking Minimum Data Set (MDS) was accurately coded to reflect actual discharge location for 1 of 3 residents (R2) reviewed for MDS accuracy. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2023, identified Entry and Discharge Reporting MDS(s) each included a select number of items from the MDS used to track residents and gather quality data at each transition point, such as when they enter or leave a nursing home. The manual instructions for section, "A2105: Discharge Status," directed to record the location to which the resident was discharged to. If to an assisted living facility (ALF), then it should be recorded as, "Code 01. Home/Community." R2's progress note, dated 8/3/26, identified R2 discharged the care center back to her ALF with her family member present. R2's belongings and education were sent along with her. However, R2's Discharge - Return Anticipated MDS, dated 8/3/26, identified R2 discharged the campus; however, recorded her discharge status as, "04 – Short-Term General Hospital (acute hospital, IPPS)." The MDS inaccurately coded R2's discharge location as the hospital and not back to the community as directed by the RAI manual. When interviewed on 8/20/26 at 10:42 a.m., registered nurse (RN)-E verified they helped complete MDSs for the campus. RN-E reviewed R2's completed MDS (dated 8/3/26) and stated it should			F0641			09/14/2026

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F0641 SS = A	Continued from page 17 have been coded as “01” and not to the hospital as it had been. RN-E verified the MDS was marked inaccurately and stated they would submit a modification for it. RN-E stated the MDS was only a tracking MDS and not used for payment reimbursement or resident care needs, however, it was important to ensure all MDSs were coded correctly. This was important to do “so there are no errors in billing or to the patient.” The facility Comprehensive Assessments and Care Planning policy, dated 10/2023, identified the MDS would be coordinated by an RN and each assessment “... must accurately reflect the resident's status, and each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.”			F0641			09/14/2026

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 8/19/26 to 8/20/26, 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 complaints were reviewed: H53103762C (3159966), H53103693C (3153950); with orders cited at 0900.		20000			09/14/2026	

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 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			09/14/2026	
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	Corrected		09/14/2026	

Minnesota Department of Health

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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 comprehensively assess and implement an effective turning and repositioning program to prevent pressure ulcer development; failed to ensure the care plan was updated with new interventions to ensure implementation; and failed to ensure a developed pressure ulcer was accurately tracked and monitored in the medical record for 1 of 3 residents (R2) reviewed for pressure ulcer care. R2 needed physical assistance with repositioning, however, no consistent repositioning program was implemented and R2's care plan was not updated as she became more at risk for pressure ulcer development. R2 then developed multiple, avoidable stage II pressure injuries on her coccyx which constituted actual harm. Findings include: The Centers for Medicare and Medicaid (CMS) State Operations Manual (SOM), Appendix PP – Guidance to Surveyors for Long Term Care Facilities, dated 7/23/2025, identified the current regulatory expectations for pressure ulcer care. This defined an avoidable pressure ulcer as, "... means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate." Further, the SOM defined stage II pressure injury as a partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed would be viable, pink or red, moist, and may also appear as an intact blister. A Vulnerable Adult Maltreatment Report (MAARC), dated 8/10/26, identified concerns about R2's care while at the care center. The report alleged R2 had been admitted to the center in late June 2026 and discharged back to her assisted living facility (ALF) on 8/3/26; however, R2 now had multiple pressure sores which had not been present prior.		20900			09/14/2026	

Minnesota Department of Health

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20900	Continued from page 3 R2’s Clinical Documentation (Admission), dated 6/29/26, identified R2 admitted to the care center and had intact long-term and short-term memory but with some difficulty making decisions about care in new settings. R2 had occasional bowel and bladder incontinence and occasional pain recorded. R2’s initial Skin Risk Observation with Braden Scale, dated 6/29/26, identified R2 had clinical risk factors for skin breakdown including an acute condition and diabetes. R2 needed partial/moderate assistance with sitting-to-lying and vice versa. R2 used a brace/splint device (on her leg) and had no current, unhealed pressure injuries or other skin problems (i.e., diabetic ulcers, infections, moisture-associated skin damage [MASD]). R2 demonstrated no nutritional concerns (i.e., cachexia, edema, decreased output) and scored a 19.00 on her Braden Scale (tool used to help predict pressure injury development risk) which recorded her as, “Not at Risk.” A section labeled, “Interventions,” recorded specific interventions staff could implement with a checkmark being placed next to them. This recorded that no measures were taken (such as a blanket cradle, trapeze) but R2 was on a turning and repositioning program and on nutritional/hydration interventions to help manage skin problems. The evaluation concluded with, “Continue Current Care Plan,” and with referrals placed to physical and occupational therapy (PT/OT). R2’s Weekly Skin Check, dated 7/2/26, identified a shower was provided and R2 had no current skin issues. R2’s admission Minimum Data Set (MDS), dated 7/5/26, identified R2 had moderate cognitive impairment and demonstrated no rejection of care behavior. R2 had multiple medical conditions including diabetes mellitus, high blood pressure, and a bone fracture. R2 needed partial/moderate assistance with rolling in bed side-to-side, going from lying to sitting, and transferring from her bed to a chair. Further, R2 had no current, unhealed pressure injuries, she was determined as not at risk for developing them, was given a pressure reducing device for her chair and bed but was not on a turning and repositioning program. R2's corresponding Pressure Ulcer/Injury Care Area Assessment (CAA), dated 7/8/26, identified the CAA triggered due to R2 needing assistance with cares, urinary status and Braden Scale score. The CAA listed, "partial/moderate for all bed mobility." The CAA then added, "Resident Braden scale sore: 19, not at risk." R2 had no current pressure injuries but "is at risk for skin breakdown." R2 received PT/OT			20900			09/14/2026

Minnesota Department of Health

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20900	Continued from page 4 and a care plan to minimize risks would be developed. R2’s next Skin Risk Observation with Braden Scale, dated 7/11/26, identified R2 continued to have some clinical risk factors present and remained occasionally incontinent of bowel. R2 continued to use a brace/splint and now the evaluation marked, “Limited Mobility/Bedfast.” R2 had no current, unhealed pressure injuries or other skin problems. However, R2’s Braden Scale score had now decreased and she was labeled, “At Risk.” The section labeled, “Interventions,” now only recorded a single intervention which was a pressure reducing device for her chair. The evaluation concluded with, “Continue Current Care Plan.” R2’s Weekly Skin Check, dated 7/14/26, identified R2 had a shower provided and had no current skin issues. R2’s next Skin Risk Observation with Braden Scale, dated 7/19/26, identified R2 continued to have some clinical risk factors, such as cardiovascular disease, and still needed partial/moderate help to turn left-to-right in bed and now needed substantial/maximal assistance with going from lying to sitting. R2 remained occasionally incontinent of bowel and no longer was using a brace/splint device as it was left unchecked. R2 continued to have no current, unhealed pressure injuries or other skin problems. However, R2’s Braden Scale score had decreased further (more at risk with the lower the score), and she continued to be labeled, “At Risk.” The section labeled, “Interventions,” now had no interventions or measures checked or recorded and the evaluation concluded, “Continue Current Care Plan.” R2’s care plan, last reviewed 7/14/26, identified R2 had an ADL self-care deficit and needed assistance of one for toileting. The plan recorded, “Resident can verbally ask for assistance and is occasionally incontinent of bowel and bladder,” adding further, “Resident has a bowel and bladder plan that will help them remain free of skin breakdown …” However, the plan lacked further details on the exact plan or timing with which R2 would be helped/offered/assisted with toileting. R2’s skin care plan, dated 6/30/26, identified R2 was at risk for an alteration in skin integrity due to diabetes, decreased mobility and impaired circulation. The plan listed a goal which read, “The resident will not develop further skin alterations.” A single intervention was listed on the care plan which read, “Resident has the following skin protective			20900			09/14/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
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20900	Continued from page 5 measures in place: (Special Mattress, barrier cream applied to dry areas as needed).” The date of this intervention was listed as 6/30/26. The care plan lacked any further interventions, such as a turning and repositioning program, to help address R2's skin risk despite her having decreasing Braden Scale score(s), being recorded as at-risk for pressure injuries on her evaluations and having impaired mobility. R2’s progress note, dated 7/24/26, identified an “open area” was now found on R2's inner buttocks. It showed redness and some minimal swelling. The note recorded, “Continuing to use cream for skin tears and between buttocks.” The note lacked any recorded measurements of the identified areas or other characteristics of the developed wound; nor evidence of what, if any, ongoing interventions the nurse placed to help promote healing of the wound. Registered nurse (RN)-B authored the note. R2’s last completed Skin Risk Observation with Braden Scale, dated 7/25/26, identified R2 had diabetes mellitus, continued to need physical assistance with most mobility tasks, and continued to have bowel incontinence. The evaluation recorded R2 had no current, unhealed pressure injuries or other skin problems and listed a Braden Scale score which now showed R2 was not at risk for pressure injury development (despite the progress note on 7/24 showing an open area). The section labeled, “Interventions,” identified the staff would elevate her edematous extremities but no other interventions, including turning and repositioning program, were marked despite an open area developing the day prior. The evaluation concluded with, “Continue Current Care Plan.” R2’s M Health Fairview Geriatrics note, dated 7/28/26, was authored by the nurse practitioner (NP)-A and recorded R2 as being seen for an episodic care visit. The note now added a concern which read, “4. Pressure ulcer of coccygeal region, stage 2 (H).” The note continued, “Patient seen for follow up ... now PU [pressure injury] coccyx in cleft 2 X 0.5 cm [centimeters] plus R medial buttock 1 cm area and L buttock 1.2 cm area both excoriated and open, no discharge.” The note listed a section labeled, “Assessment/Plan,” which reiterated the pressure injuries on the coccyx with dictation reading, “... coccyx plus bilateral buttocks open areas with maceration/excoriation.” NP-A directed to start barrier cream twice daily, have the wound nurse evaluate the area that week, and offload as possible.		20900			09/14/2026	

Minnesota Department of Health

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20900	Continued from page 6 R2’s Weekly Skin Check, dated 8/1/26, identified R2 was given a shower and recorded a skin issue as, “Other type of alteration.” The form outlined R2 as having “excoriation and two open areas noted to coccyx area.” The completed form lacked any written dictation of what, if any, interventions were done for the area or further wound characteristics (i.e., measurements, odor, drainage). R2’s progress note, dated 8/4/26 (late entry for 7/28/26), identified the campus wound nurse (RN)-A had attempted to see R2 but she was not in her room. A subsequent note, dated 8/4/26 (late entry for 7/29/26), identified RN-A again attempted to see R2 but she was going to a medical appointment but R2 was seen by the nurse practitioner who had placed orders for the developed wound. These notes lacked evidence of any reapproach of R2 or what, if any, actions RN-A had given to other nurses for evaluating the wound or placing new interventions for it since they had been unable to do so. R2’s Treatment Administration History (TAR), dated 7/2026, identified R2’s recorded treatments with staff initials and date/time of them to show what was completed. This listed an intervention to apply barrier cream to the developed pressure ulcer twice daily with a start date recorded, “07/28/2026 – 08/03/2026 (DC Date).” This was first recorded as completed on the evening medication pass on 7/28/26. The TAR lacked any interventions for offloading or barrier cream prior to 7/28/26 despite R2 needing assistance with mobility, having incontinence, and developing the pressure injury on 7/24/26 (four days prior). R2’s Wound Management details, located within the medical record, identified R2 had multiple bruises which were identified upon admission. However, it lacked evidence that the developed pressure ulcers (first identified on 7/24) were added or tracked in this detail report until 8/3/26 when R3 discharged the care center back to her ALF. On 8/20/26 at 8:34 a.m., a telephone call was placed to R2’s family member (FM)-D to discuss R2’s care while at the care center. However, they were not reached. When interviewed on 8/20/26 at 8:40 a.m., NA-A stated care plans were communicated to the floor staff and directed how to transfer a resident and if they were on a repositioning program or not. NA-A stated all residents were on a “check on them” program every few hours. If someone was helped with toileting or repositioning, then it should be			20900			09/14/2026

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20900	Continued from page 7 recorded in the POC charting each time the care was provided adding, “Every time you go in the room [record it].” NA-A stated they vaguely remembered working with R2 and recalled applying barrier cream to R2’s coccyx and bottom and believed it was something being done the entire time R2 had been admitted to the care center. R2 did not have any skin issues or wounds to NA-A’s recall. When interviewed on 8/20/26 at 8:56 a.m., NA-B stated a resident on a repositioning program would be identified on the care plan which was then placed in a folder for staff to review each day to be aware of that. The staff just tracked the repositioning themselves using a pen and paper and whether that information was charted in the POC data would be “a great question for the nurses.” NA-B recalled there, at times, being a question about it on the POC to answer but it was rather just a single “yes or no” question about if you did it or not. NA-B stated they thought the nurses charted more specific interventions for pressure ulcer prevention in their records. NA-B recalled working with R2 when she was at the care center and described R2 as needing assist of one with transfers and most tasks except eating. R2 was also incontinent of bowel and bladder. R2 was not on a repositioning or toileting program but rather only “just when she would ask [for help],” adding R2 didn’t like to lay in her bed much but rather spent a lot of time in her recliner chair. The staff would, if R2 asked for it, place R2’s wheelchair cushion in the recliner, too. NA-B recalled working on 7/24/26 when they saw R2’s coccyx and the wounds for the first time. They appeared “a little red” and like “a little open wound.” NA-B notified the nurse about it, who told them to apply barrier cream on it which had already been present in the room. NA-B stated they were unsure where or how long staff had been applying barrier cream to R2’s coccyx prior to the wound development. NA-B reiterated R2 had not been on a turning and repositioning program prior to or following the wound developing to their recall. R2’s Point of Care (POC) History report, dated 7/17/26 to 8/4/26, identified the care recorded by the nursing assistant (NA) staff members for the period. R2 had no recorded behaviors and had multiple episodes of bladder and bowel incontinence. R2’s ability to go from sitting-to-lying and vice versa was recorded mostly as, “Substantial/maximal assistance,” with some, “Dependent.” The complete POC documentation lacked evidence that R2 was placed on a repositioning program or having any consistent turning and repositioning completed for the period.			20900			09/14/2026

Minnesota Department of Health

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20900	Continued from page 8 R2’s medical record was reviewed and lacked evidence R2 had been started on a consistent turning and repositioning program to help prevent pressure ulcer development despite needing physical assistance with transfers and bed mobility; lacked evidence R2’s skin ability to tolerate prolonged periods of pressure (i.e., tissue tolerance) had ever been considered or evaluated in the recliner chair since she spent much of her time there; lacked evidence the pressure ulcers were comprehensively assessed when they developed to determine what interventions were needed to promote healing and prevent continued decline; and lacked evidence of a consistent treatment being implemented until 7/28/26 which was four days after the area was first charted. Further, the record lacked evidence R2’s skin care plan was ever adjusted with new interventions despite a worsening Braden Scare being charted. R2 then developed three stage II pressure ulcers as diagnosed by the provider. When interviewed on 8/20/26 at 9:42 a.m., RN-B explained if a new skin impairment, including a pressure injury, was identified then the nurse who first saw it was supposed to assess it and then update the wound nurse (RN-A) or the unit manager about it. The wound should also be measured and all the actions taken should be recorded in the progress notes. The wound nurse would then evaluate the wound, and they would stage it, if needed, and make further treatment recommendations and communicate with the physician. RN-B stated the Weekly Skin Check forms were to be completed on the scheduled bath day for the resident and should include both current and new skin impairments but if the wound had already been assessed, then staff would just recorded any changes to it on that form and not go into full detail about it. RN-B stated the floor nurses also complete the Skin Risk Observation/Braden forms and should place checkmarks next to the interventions they have orders to do for the person but just because there were no orders for someone to be repositioned, the nurses and aides could still do that adding, “I feel like that is common sense.” RN-B stated there had been some training on how to complete those skin forms when they started working at the care center a few months prior, but not “down to the detail” of exactly what check-marking the items meant or who then updates the care plan with those marked interventions. RN-B stated they felt the unit manager would be the person who updated the care plan with interventions as the floor staff more just identified the wound and then the unit manager would take over the care and			20900			09/14/2026

Minnesota Department of Health

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20900	Continued from page 9 care plan adjustments moving forward adding, “We [floor nurses] don’t do any changes to the care plan unless we’re told to.” RN-B recalled working with R2 and described her as “pretty immobile” and often sleeping in her recliner chair instead of her bed. There was rarely, if ever, a cushion used in the recliner seat to RN-B’s recall but sometimes R2 would ask for a pillow on her side due to hip pain. R2 was “pretty incontinent” of bowel and bladder but did void in the toilet at times when assisted there. RN-B recalled the wound they saw on R2’s bottom area on 7/24/26 and described it as “red” but with intact skin looking like “two pennies next to each other.” There were multiple areas present and the aide mentioned there was some barrier cream in the bathroom, so RN-B told the aide to just apply that. R2 reported the area was “a little painful” too. RN-B then updated the nurse they were working with that day for orientation about the wound but was unable to recall the nurse’s name. RN-B stated they did not update the wound nurse about the wound as, at that time, they did not know who it was even; and they were unsure if the nurse they reported it to did either, rather the nurse they reported it to just said to apply the barrier cream and “keep an eye on it.” RN-B stated they could not recall if R2 was on a turn and reposition program or not but did recall seeing her often slide down in her wheelchair and having a slumped appearance, so staff would have to boost her back up often. RN-B stated they were unsure how the NA staff members chart repositioning if someone was on a repositioning program adding, “I have never seen their charting.” RN-B then stated they thought someone on a repositioning or offloading program would show up on the TAR with an intervention for the nurses to record. The nurses could also write it in a progress note, but nobody had ever directed them to do that, rather it was just to get the information into the medical record. RN-B verified R2 was “pretty healthy” and eating well during their stay at the care center. R2 was not considered in terminal condition, either. Further, RN-B stated they were unsure who or how often someone evaluates the skin tolerance to pressure (i.e., tissue tolerance) and did not know if occupational therapy (OT) had ever been involved with R2’s skin interventions or not. When interviewed on 8/20/26 at 10:48 a.m., occupational therapist (OT)-A recalled working with R2 and reviewed her medical record. R2 had “waxing and waning” cognition and family had been considering memory care options at the end of her admission. R2 had a foot injury and wore a CAM boot due to fractures going from weight-bearing as			20900			09/14/2026

Minnesota Department of Health

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20900	Continued from page 10 tolerated (WBAT) to toe-touch weight bearing (TTWB) mid-stay after an orthopedics appointment. OT-A recalled R2 struggled at times to use the call light system as it was different than the style she had been using at her ALF. Upon admission, OT-A stated R2 needed moderate to maximum assistance with repositioning then progressed to needing more minimal to moderate assistance towards the end of her stay. OT-A stated they did not think R2 would know to reposition herself independently without cues or help and needed physical help to do that throughout her admission. OT-A stated they did not think R2 had ever been on a repositioning program and could not recall nursing staff ever reaching out to them (OT) about her spending a lot of time in her recliner chair. OT-A stated use of a recliner chair instead of a bed was “something I want to look into more” as it did not provide the same “offloading pressure” as a mattress would have. The OT could even then do a “pressure-mapping” on R2 to help determine more interventions to relieve pressure in the wheelchair or recliner. OT-A recalled doing a “seat dumping” on R2’s wheelchair but that was more for her sliding and her falling. OT-A stated they were unaware R2 had developed pressure ulcers at the care center. On 8/20/26 at 11:29 a.m., a group interview was held with the director of nursing (DON), RN-A, nurse manager (RN)-D, and the regional director of clinical services (RDCS). RN-D explained that when a resident was admitted to the care center, a skin check was completed and recorded. If wounds existed, then they would be recorded in the Wound Management section and tracked, and RN-A would be updated about them. If there is no skin issue present upon admission, then a Braden Scale is completed and, depending on that result, they are placed on a repositioning program if they are at risk. The Braden Scale is then repeated weekly for four weeks by the floor nurses. The care plan “normally” was then updated by the manager if the person was at risk for skin breakdown. RN-A stated the floor nurses were also able to update the care plan with a reposition program and consult with other resources, such as the dietitian, if they determined they needed to do so about skin risk or wounds. DON explained they no longer have tissue tolerance review as part of their assessment process as the weekly skin checks and daily general observations of skin with care replaced it. RN-A stated if a resident was using a device frequently, like a recliner, then they could visit with OT and have them review it and provide a cushion for it, if needed, but the resident would still likely need to be offloaded by the staff. RN-D verified R2 needed physical help to reposition, and			20900			09/14/2026

Minnesota Department of Health

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20900	Continued from page 11 the care plan should be updated with interventions as the Skin Risk/Braden evaluations are completed. The timeline of events with R2's wound was reviewed. RN-D recalled seeing the progress note (dated 7/24) about the wound concern and updated the provider about it who saw it then (on 7/28) and ordered barrier cream for it. The provider only told them it was "some excoriation but nothing major" and never used the term 'pressure injury' which would have caused them to have a hastier response to it. RN-A and RN-D stated they both attempted to evaluate the wound between 7/24 and 7/28 but had been unable to connect with R2 which is why the notes were entered into the system late (after R2 discharged). RN-A verified the floor nurses could also have fully assessed the wound and started treatments on it since they were unable to see it. RN-D verified the medical record lacked a re-assessment of the wound after it developed or revisions to the care plan and stated they never updated the care plan after the wounds developed as they wanted to evaluate the wound first before adding them to the care plan. RN-D also acknowledged that the care plan lacked any further interventions for skin risk other than the initial single intervention loaded despite the worsening Braden Scale scores being recorded. DON stated that if a resident was on a reposition program, the NA staff should be recording that in the POC charting or the nurses could record it on the TAR. However, R2 did not have this charting in her record and had not been placed on a reposition program per the care plan, either. DON stated the first time they had learned about R2 developing multiple pressure injuries was after R2 discharged and her ALF reached out asking about the wounds. When asked if R2 would have still developed the pressure injuries if all these actions, such as being placed on a repositioning program and having new care plan interventions added as her Braden Scale score worsened, had been taken, RN-D stated they didn't think R2 needed much help to reposition at the beginning of her admission and felt the nurses were checking on her routinely. DON stated they would keep looking for more information in the medical record to show what, if any, additional actions or interventions were being done and provide them if located. No further information was received. When interviewed on 8/19/26 at 1:49 p.m., NP-A stated they were the primary medical provider to R2 while she had been at the care center. NP-A stated they were first notified about the developed skin impairment for R2 on 7/28/26 which they went and			20900			09/14/2026

Minnesota Department of Health

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20900	Continued from page 12 evaluated. There were three areas total and each was a stage II pressure ulcer. The areas appeared, “red and raw” but had no depth or slough present rather just, “raw, macerated areas.” NP-A stated if a wound developed between care visits, then the unit manager could call and update them about it. NP-A stated the charting on 7/24/26 from the nurse wasn’t maybe enough to warrant an update to the provider alone as some nurses are newer or more raw than others. NP-A stated the wound nurse should have been made aware when the skin was first seen, and they could have evaluated the wound and then contacted the provider for input if needed adding, “That should have happened.” The facility Prevention and Treatment of Skin Breakdown policy, dated 6/2026, identified residents were assessed upon admission and weekly thereafter for four weeks using the Skin Risk Assessment. The policy recorded, “Those residents at an increased risk for impaired skin integrity are provided preventative measures to reduce the potential for skin breakdown.” The policy outlined a care plan would be implemented and updated for skin risk interventions based on areas of risk, resident assessment, a Braden of 15 or less, and resident preferences. Resident’s skin was observed daily with cares and concerns would be reported to the nurse; a therapy consult would be placed as appropriate. If a new pressure injury was identified after admission, the policy directed to document it in the medical record, initiate standing orders for wound care, notify the provider and resident representative, notify the supervisor (manager) and evaluate current pressure reduction interventions and revise the care plan. The documentation should reflect these actions completed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on pressure ulcer risk assessment, care planning, and monitoring to ensure accuracy and alignment with the regulations. Then, could educate staff on the expectations and then audit records to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 Days			20900			09/14/2026