STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Health Center Innsbruck	1101 Black Oak Drive New Brighton, MN 55112

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and documentation review the facility failed to notify the medical provider of a change of condition for 1 of 3 residents (R1) reviewed when R1 reported to the nurse she was not eating or drinking because it hurts my intestine and rectum, and she had loose stools, staff notified the provider three days later. Findings include: R1's annual Minimum Data Sheet (MDS) dated [DATE], indicated she had no cognitive impairment, behaviors, or rejection of care. She used a walker independently and continent of bowel and urine. She did not have a risk for skin impairment or wounds. Her care areas triggered activities of daily living (ADLSs), and nutrition. R1's care plan dated 6/2/26, indicated she had pain from her left knee, decreased strength, needed staff to help with daily hygiene, and a fall risk. She was continent of bowel and bladder. RN-A's nursing progress note dated 6/14/26 at 11:08 p.m., indicated R1 told her she had loose stool since Friday (3 days earlier.) She did not tell nursing staff prior. RN-A offered Imodium (medication to treat loose stool), but she declined. RN-A indicated staff would update the provider on 6/15/26, and her vital signs were stable. R1's medical record indicated there were no progress notes dated 6/15/26. RN-D's nursing progress note dated 6/16/26 at 11:48 a.m., indicated R1 had loose stool on the night shift, but none at the time of her assessment. R1 stated I don't want to eat because it hurts my intestine and rectum. RN-D's intervention indicated staff would continue to monitor R1's status. RN-C's nursing progress note dated 6/17/26 at 11:35 a.m., indicated she updated the medical provider triage nurse about R1's complaint of loose stool, weakness, and rectal pain. RN-B's nursing progress note dated 6/17/26 at 12:28 p.m., indicated R1 complained of continuous rectal burning and pain. The pain worsened with activity. R1 stated her stool was black, and very loose. She stopped eating food for the past few days because when she ate anything, she would have increased stool and worsening pain. The nurse practitioner (NP)-A called back with an order for Imodium. NP-A's encounter note dated 6/18/26, indicated R1 had buttock pain and was unable to sit up. She found localized buttock soft tissue inflammation without exam and was concerned about cellulitis. Her plan was for staff to give Imodium as needed for loose stool, encourage food and fluids and if her condition did not improve staff should send her to the emergency room for an evaluation. RN-C's nursing progress note dated 6/18/26 at 1:15 p.m., indicated R1 continued to have unrelieved rectal pain, loose stool, weakness, short of breath, and anything she ate or drank passed right through her leading to increased pain. She was sent to the emergency room for evaluation. R1's facility event document dated 6/18/26 at 2:42 p.m., indicated on 6/12/26, she developed loose stool, rectal pain, weakness with shortness of breath. During an interview on 6/24/26 at 8:47 p.m., family member (FM)-A stated R1 complained about butt pain. She received a text message from R1 on 6/14/26 at 8:47 p.m., indicating she had been sick since Friday and if she did not improve, she would call 911. She was unable to eat because the food ran right through her. On 6/15/26 at 1:28 p.m. R1 indicated the staff were doing nothing but offering her Imodium but she declined because it would only make the loose stool worse. R1 added my rectum was on fire she was unable to sit on the edge of her bed. She felt the staff were doing nothing to help her. She tried to get ahold of someone at the facility, but no one answered or returned her phone call. During an interview (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 6/24/26 at 2:14 p.m., R1 stated she did not feel good over the weekend. When the nurse came into her room, she asked her what the facility's protocol was when a resident was unable to eat or sit up. The nurse did not listen to her. While she took a shower, she could feel the rectal inflammation, but the evening nurse did not say anything. When the NP-A examined her the next day she was told the medical doctor would see her on Monday (four days later.) The hospital found a rectal wound infection, and it spread to her blood. She told the staff what was going on but all they told her was to eat and drink fluids and take Imodium. She said the staff did not listen to her concerns and felt like she was talking to the wall. She told the nurse on 6/17/26, she felt pressure on the inside of her rectum. During an interview on 6/24/26 at 4:00 p.m., RN-B stated earlier in the shift she noticed R1 was not up walking in the hallway. She checked in on her and found her lying in bed talking on her phone. R1 told her she had internal rectal pain, and every time she tried to eat food the loose stool would worsen causing her more pain. R1 declined an examination because the pain was internal not external. She updated RN-C. She received an order from the NP-A for Imodium, and she would visit R1 in the morning. During an interview on 6/24/26 at 4:36 p.m., RN-C stated she first learned about R1's loose stool on 6/15/26, when she returned to work. She spoke with R1 who told her the stool had stopped that morning. On 6/16/26, she was notified R1 stopped eating because it worsened her loose stool, but she did take some yogurt. On 6/17/26, RN-B told her R1 continued to have loose stool, and internal rectal pain. She called the provider's triage nurse. She added, the staff on 6/15/26, should have assessed her status and notified the NP of their findings. During an interview on 6/24/26 at 4:53 p.m., RN-D stated he assessed R1 on 6/16/26, and was told the loose stool had stopped. He checked her vital signs and encouraged her to eat and drink fluids. He did not update the provider because the loose stool stopped, and her pain was related to eating. He reported his findings to the next shift nurse. During an interview on 6/24/26 at 5:07 p.m., the director of nursing (DON) stated if R1 told her daughter she was having severe pain her daughter should have called the facility. If R1 was concerned about her care at the facility she could have spoken to the social worker because she made her own decisions and had no cognitive impairment. When NP-A examined her on 6/18/26, she left the building without talking to the staff or writing down any orders. When the staff reviewed her visit note later that day, they found staff should send R1 to the hospital if her condition worsened. He checked on R1 in the afternoon on 6/18/26, and asked R1 what NP-A told her. She replied she would have the provider see her on 6/22/26. R1 agreed to go to the hospital, and she was transferred. During an interview on 6/25/26 at 9:53 a.m., NP-A stated she first learned about R1's loose stool, rectal pain, weakness and not eating on 6/17/26. She sent an order for Imodium and planned to see her in the morning. On 6/18/26, she examined R1 who told her she had loose green, greasy looking stool, and internal rectal pain preventing her from sitting up. She examined the outer rectal area, noted red firmness, and thought it was irritation caused by the frequent loose stool. She tried to talk R1 into going to the hospital, but she declined and wanted to wait to see if she got better. After examining R1, she left the building without talking to staff. She would have preferred the staff to update her 6/15/26 when R1 first reported three days of loose stool. Interview on 6/25/26 at 10:27 a.m., facility medical director (MD-A) stated the NP-A ignored significant facts, and then later wrote her findings and instructions on her encounter note instead of talking to the nursing staff and writing her orders in the medical chart for processing. He added, the facility staff were monitoring R1 for three or four days, called the provider who gave them a weak order. The NP-A should have ordered blood work to look for an infection and stayed with the resident until she agreed to be transferred to the hospital for further evaluation. R1's face sheet dated 6/25/26, indicated she had an acute and chronic congestive heart failure, failure to thrive, anemia, swollen legs, chronic kidney disease, and diabetes. The facility policy Change in Condition, Resident Examination and Evaluation copyright date 2025, indicated nursing staff would work within their standard of practice to check for change in condition via observations, physical examination, interview, and discussion with other staff. If a resident refused the examination, they would report to the supervisor or DON and document findings (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the chart. Staff would update the provider regarding the residents' concerns and findings. In addition, the family would be contacted, staff would document their findings, interventions, and provider orders.