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	04/16/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure a dignified dining experience for 1 of 1 resident (R61). Findings include:R61's quarterly Minimum Data Set (MDS) dated [DATE], indicated severely impaired cognition and diagnoses of dementia and encephalopathy (disease of the brain that causes altered brain function or structure, often resulting in cognitive, behavioral, or neurological impairments). It further indicated R61 required substantial assistance with dressing.During observation on 4/15/26 at 7:11 a.m., R61 was sitting in the dining room at a table with 3 other residents. He was wearing a shirt and hip protectors (nude colored compression type shorts with padding on the hips). During observation and interview on 4/15/26 at 7:28 a.m., trained medication assistant (TMA)-A verified R61 was sitting in the dining room wearing a shirt and hip protectors stating the residents don't normally sit in the dining room just wearing their hip protectors because they are meant to be worn under clothes. R61 had been trying to get out of bed, and the day shift just arrived. TMA-A then went back to the medication cart and did not attempt to cover R61 with a blanket or bring him back to his room for pants. During observation on 4/15/26 at 7:30 a.m., social services (SS)-A walked past R61 looked down and saw he was only wearing his hip protector. SS-A went to the storage closet, got a blanket, and put it over R61's lap stating, Your legs looked a little cold.During observation on 4/15/26 at 9:34 a.m., (NA)-A stated hip protectors were meant to be worn under clothing and residents shouldn't be wearing it by itself, especially in common areas because it is like underwear. During interview on 4/15/26 at 9:47 a.m., NA-E hip protectors were meant to be worn under the resident's clothing, and they shouldn't be sitting in common areas or the dining room without clothing over them. During interview on 4/15/26 at 9:57 a.m., licensed practical nurse (LPN)-A stated residents should not be out in the common areas with just hip protectors on and they are meant to be worn under clothing. LPN-A also verified that wearing hip protectors without clothing over it, would not be considered a dignified experience.During interview on 4/16/26 at 9:33 a.m., registered nurse (RN)-C stated hip protectors were meant to be worn under clothes, and were like underwear, and shouldn't be worn in common areas. During interview on 4/16/26 at1:23 p.m., the director of nursing (DON) stated hip protectors should be worn under clothing and if the resident was resistive to getting dressed, the nursing assistants should ask for help and not just bring them out into a common area or dining room to sit. A facility policy titled resident's rights dated 11/28/17, indicated the facility acts to protect and ensure the rights of residents.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a resident's wishes for resuscitation were accurately documented in all areas of the medical record for 1 of 2 residents reviewed for inconsistent advanced directives. Findings include:R10's quarterly Minimum Data Set (MDS) dated [DATE], R10 had severe cognitive impairment, required substantial to maximal assistance for most activities of daily living (ADLs) and was receiving hospice care. R10's diagnoses included dementia, adult failure to thrive, and encounter for palliative care. R10's care plan dated [DATE], indicated, My code status will be honored.See M.D. order. R10's care plan further indicated resident received hospice services and that Resident's preferred wishes for end of life will be honored. R10's care plan instructed staff to coordinate with hospice providers and to refer to her hospice care plan. R10's admission clinical documentation assessments dated [DATE], [DATE] and [DATE], identified R10's advance care planning included DNR (do not resuscitate). R10's quarterly clinical documentation assessments dated [DATE] and [DATE], identified R10's advance care planning included DNR. R10's admission documents dated [DATE], indicated additional after hospital orders to include Treatment Options: DNR. R10's active provider order dated [DATE], indicated, Treatment Options: DNR. R10's order history report printed [DATE], indicated, Treatment Options: DNR/DNI [do not intubate] Special Instructions: See POLST [provider order for life-sustaining treatment] signed [DATE]. R10' order history from [DATE] through [DATE] lacked any evidence Full Code or CPR was ever ordered. R10's POLST dated by family member (FM)-B and nurse practitioner (NP)-A on [DATE], and scanned into the resident documents section of R10's electronic health record (EHR) indicated, Attempt Resuscitation/CPR.Full Treatment. Use intubation, advanced airway interventions, and mechanical ventilation as indicated. R10's provider visit note by NP-A dated [DATE], indicated, Reviewed POLST with patient and spouse, they would like her to be full code.CODE STATUS/ADVANCED DIRECTIVES: DNR/DNI. R10's health care directive dated [DATE], indicated, If I am in a terminal condition and cannot express my wishes, I wish to be allowed to die naturally and not be kept alive by artificial means or heroic measures. During interview on [DATE] at 5:28 p.m., licensed practical nurse (LPN)-A stated he would look in the EMAR (electronic medication administration record) in the resident's EHR to see their current code status. LPN-A pulled up his EMAR list which indicated DNR in bold, black letters within a red rectangle background under R10's name. LPN-A further stated the same indication was also seen in the resident header in the EHR. During interview on [DATE] at 5:30 p.m., registered nurse (RN)-B stated she would locate a resident's code status in the EHR under orders, on the face sheet or in the resident header. RN-B verified all three of those locations indicated DNR for R10. RN-B further stated code status could also be found in the resident's hard chart as well and opened R10's hard chart to the POLST. The original POLST (on yellow paper) in R10's chart was signed on [DATE] and indicated full code. There was a red line from the lower left corner to the upper right corner, and the word VOID was written on it. RN-B could not explain when this documented had been voided. During interview on [DATE] at 5:32 p.m., RN-C stated R10 was on hospice and so the updated POLST should be in the hospice binder. RN-C opened R10's hospice binder and found a copy of the POLST that was in her hard chart, signed and dated on [DATE], and did not indicate that the documented had been voided. RN-C could not explain why there was a discrepancy but stated she was positive R10's current code status was DNR. RN-C stated the health unit coordinator (HUC) should be able to provide an explanation and find the correct, updated POLST. During interview on [DATE] at 5:50 p.m., HUC confirmed the POLST in R10's EHR was scanned into resident documents on [DATE] and matched the POLST found in R10's hard chart and hospice binder. HUC stated R10 had returned to the hospital a couple times after initial admission and that she was admitted from the hospital as DNR each time. HUC could not explain why there was a discrepancy with the POLST and orders in R10's EHR. During (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on [DATE] at 1:58 p.m., FM-A stated his understanding was that R10 was DNR and had been since entering hospice back in July of 2025. FM-A stated he had a health care directive for R10 before her cognitive decline which indicated she wanted to have a natural death. During interview on [DATE] at 12:43 p.m., FM-B stated could not recall discussing or signing anything regarding R10's code status, but thought since R10 was on hospice, that meant they would not resuscitate and would allow a natural death. During interview on [DATE] at 12:54 p.m., RN-C state R10's POLST should have been reviewed and updated if needed when R10 signed onto hospice services. RN-C further stated code status should be reflected accurately throughout the resident's recorder-paper or electronic, to ensure the resident would receive their desired care in the case they were found unresponsive. During interview on [DATE] at 1:38 p.m., hospice nurse (RN-D) stated her understanding was that R10 was DNR and could not explain why the POLST in the hospice binder did not reflect that. During interview on [DATE] at 1:43 p.m., director of nursing (DON) stated the POLST should match the documentation in the residents EHR. DON further stated that the provider was responsible for ensuring the completion and accuracy of the resident's POLST. DON stated that in R10's case, hospice would be considered the provider, and they should have reviewed R10's POLST upon admission to hospice and ensured an updated and accurate copy was in her hospice chart. DON further stated the POLST that was uploaded to the resident document section should have been voided and a new POLST - when completed by hospice - should have been uploaded. DON understood there could be a concern since the uploaded POLST did not match the provider order in R10's EHR. Facility policy Medical Orders (POLST) undated, indicated a POLST was a medical order completed and signed by a healthcare professional as well as the resident or healthcare agent that outlined the resident's wishes concerning care at life's end. The policy further indicated the POLST would be uploaded into the resident's EHR in the Advance Care Planning section of resident documents.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to implement interventions for 1 of 1 resident (R47) who required alternate means of communication due to English as a second language.Findings include:R47's quarterly Minimum Data Set (MDS) dated [DATE], indicated R47 had severe cognitive impairment and diagnosed with aphasia (difficulty with communication) and dementia. Additionally, diagnosed with hemiplegia and hemiparesis following a cardiovascular accident affecting right dominate side, had reduced mobility. R47 required set-up help with eating, supervision for hygiene needs and impairment on one side, need assistance with dressing, and required moderate assistance for bed mobility. The MDS indicated R47 minimal difficulty with hearing, and was Vietnamese.R47's care plan dated 3/11/26, indicated R47 had behavioral symptoms with placing self on the floor, non-compliant with medication administration related to possible cognitive deficits. the care plan indicated R47 preferred to speak English unless otherwise noted. The care plan indicated that R47 was dependent on staff for meeting his emotional, intellectual, physical, and social needs. During an interview on 4/13/26 at 5:30 p.m., R47 (via interpreter) stated, he was not happy with the care, when he asked staff for something, it was not received. When he attempted to speak English to receive pain medication, he did not receive any. R47 didn't feel heard especially when it comes to meeting his needs. R47 stated he did not have additional ways to communicate with staff, no communication board with pictures, no pain pictures to point at, and staff did not obtain an interpreter. R47 further stated I am treated like I am nothing. He attempted to talk to staff, but staff did not understand or follow through. During an interview on 4/13/26 at 5:50 p.m., family member (FM)-D stated communication was a problem between staff and R47. FM-D didn't know about how the facility implements interpreter services. FM-D further stated the facility had not offered an interpreter, even for care conferences and it would be helpful if they did. Furthermore, FM-D stated the facility did not meet R47's communication needs.During an observation and interview on 4/14/26 at 9:06 a.m., R47 was in the dining room. R47 lifted his left hand up to gesture he needed something. The dietary staff member brought him a roll. When asked R47 if he received what he wanted, R47 shook head no.During interview on 4/16/26 at 11:05 a.m., director of nursing (DON) stated the expectation was for staff to utilize interpreter services, place it their plan of care and care conference, offer and document. Clear communication was important because it drives cares and what happens daily for the residents. During interview on 4/16/26 at 11:31 a.m., registered nurse (RN)-E stated the expectation was to provide interpreter services for English as a second language or non-English speaking residents. The process to obtain an interpreter was to contact health unit coordinator (HUC) she had a sheet of paper with the information. RN-E confirmed R47 received the cares he requires by asking and no other communication assistance was used.During interview on 4/16/26 at 12:32 p.m., social service (SS)-A stated the facility has residents that have alternative primary languages. The facility offered translation services, and the staff were trained to provide translation services. During interview on 4/16/26 at 2:43 p.m., nursing assistant (NA)-E stated she did not know how to obtain an interpreter for a resident but would ask the manager.The facility's Communication with Persons with Limited English Proficiency policy undated, indicated language assistance will be provided through use of competent bilingual staff, staff interpreters, contracts, or formal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure facial hair was removed for 1 of 1 resident (R3) who required assistance with hygiene and was reviewed for activities of daily living (ADL).Findings Include:R3's comprehensive Minimum Date Set (MDS) dated [DATE], identified R3 had severe cognitive. Diagnoses included cerebral infarction (stroke) aphasia (difficulty communicating) and hemiplegia/hemiparesis (weakness/paralysis) of the left side. The MDS indicated R3 required maximal assistance with upper and lower body, and dependent on staff for all personal hygiene.R3's care plan revised on 2/5/26, identified ADL self- care deficient related to cerebral infarction. Interventions included maximal staff assistance with dressing, bathing and personal hygiene. The care plan directed that R3's facial hair was to be shaved daily. R3 had a personal electric shaver available. R3's medical record lacked R3 had refused to be shaved. During an interview on 4/14/26 at 9:05 a.m., family member (FM)-C stated R3 needed assistance with all cares. and wanted to be shaved daily. During an observation and interview on 4/14/25 at 12:56 p.m., R3's companion was in the room. R3's companion asked if R3 wanted to be shaved. R3 nodded yes, and task was shaved. During an observation and interview on 4/15/25 at 2:26 p.m., R3 had multiple white facial whiskers approximately 1/8 inch in length on his cheeks, chin and around his mouth. When asked if he liked whiskers, R3 shook his head, no.During an observation and interview on 4/16/26 at 7:38 a.m., R3 had a full face of white whiskers approximately 1/4 inch in length. When asked if he wanted to be clean shaven, R3 nodded head yes. When asked if he liked having whiskers on his face, indicated, no.During an interview on 4/16/26 at 8:23 a.m., nursing assistant (NA)-F stated she had not provided morning care to R3. NA-F verified R3's facial hair looked long and confirmed the care plan required daily shaving. NA-F wasn't sure why R3 had not been shaved and stated assisting with shaving was important to maintain dignity. During an interview on 4/16/26 at 11:11 a.m., director of nursing (DON) stated staff were expected to provide care in accordance with the care plan. The DON stated refusals should be documented. The DON further stated staff were expected to assist residents with grooming tasks, including shaving, when residents were unable to do so independently. During an interview on 4/16/26 at 11:36 a.m., registered nurse (RN)-E stated staff were expected to follow the care plan and provide consistent care. RN-E stated ADL's, including grooming, were important to maintain resident dignity. The facility policy titled Activity of Daily Living (ADL) 6/21, indicated residents were to receive necessary services to maintain grooming, personal hygiene, nutrition and mobility. The policy required staff to provide ADL's care accordance with the resident's care plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure coordination of care through on going communication with hospice services for 1 of 1 residents (R10) reviewed for hospice had discrepancy in code status documentation identified and not resolved timely. Findings include:R10's quarterly Minimum Data Set (MDS) dated [DATE], R10 had severe cognitive impairment, required substantial to maximal assistance for most activities of daily living (ADLs) and was receiving hospice care. R10's diagnoses included dementia, adult failure to thrive, and encounter for palliative care. R10's care plan dated [DATE], indicated, My code status will be honored.See M.D. order. R10's care plan further indicated resident received hospice services and that Resident's preferred wishes for end of life will be honored. R10's care plan instructed staff to coordinate with hospice providers and to refer to her hospice care plan. R10's admission clinical documentation assessments dated [DATE], [DATE] and [DATE], identified R10's advance care planning included DNR (do not resuscitate). R10's quarterly clinical documentation assessments dated [DATE] and [DATE], identified R10's advance care planning included DNR. R10's admission documents dated [DATE], indicated additional after hospital orders to include Treatment Options: DNR. R10's active provider order dated [DATE], indicated, Treatment Options: DNR. R10's order history report printed [DATE], indicated, Treatment Options: DNR/DNI [do not intubate] Special Instructions: See POLST [provider order for life-sustaining treatment] signed [DATE]. R10' order history from [DATE] through [DATE] lacked any evidence Full Code or CPR was ever ordered. R10's POLST dated by family member (FM)-B and nurse practitioner (NP)-A on [DATE], and scanned into the resident documents section of R10's electronic health record (EHR) indicated, Attempt Resuscitation/CPR.Full Treatment. Use intubation, advanced airway interventions, and mechanical ventilation as indicated. R10's provider visit note by NP-A dated [DATE], indicated, Reviewed POLST with patient and spouse, they would like her to be full code.CODE STATUS/ADVANCED DIRECTIVES: DNR/DNI. R10's health care directive dated [DATE], indicated, If I am in a terminal condition and cannot express my wishes, I wish to be allowed to die naturally and not be kept alive by artificial means or heroic measures. R10's hospice progress note dated [DATE], indicated, Son [FM-A] provided copy of [R10's] health care directive via email. He said he does not have a POLST form. R10's hospice progress note dated [DATE], indicated, Left son [FM-A] a VM [voicemail] message to provide update and to inquire whether family was planning to update POLST. During interview on [DATE] at 5:28 p.m., licensed practical nurse (LPN)-A stated he would look in the EMAR (electronic medication administration record) in the resident's EHR to see their current code status. LPN-A pulled up his EMAR list which indicated DNR in bold, black letters within a red rectangle background under R10's name. LPN-A further stated the same indication was also seen in the resident header in the EHR. During interview on [DATE] at 5:30 p.m., registered nurse (RN)-B stated she would locate a resident's code status in the EHR under orders, on the face sheet or in the resident header. RN-B verified all three of those locations indicated DNR for R10. RN-B further stated code status could also be found in the resident's hard chart as well, and opened R10's hard chart to the POLST. The original POLST (on yellow paper) in R10's chart was signed on [DATE] and indicated full code. There was a red line from the lower left corner to the upper right corner, and the word void was written on it. RN-B could not explain when this documented had been voided. During interview on [DATE] at 5:32 p.m., RN-C stated R10 was on hospice and so the updated POLST should be in the hospice binder. RN-C opened R10's hospice binder and found a copy of the POLST that was in her hard chart, signed and dated on [DATE], and did not indicated that the documented had been voided. RN-C could not explain why there was a discrepancy, but stated she was positive R10's current code status was DNR. RN-C stated the health unit coordinator (HUC) should be able to provide an explanation and find the correct, updated POLST. During interview on [DATE] at 5:50 p.m., HUC confirmed the POLST in R10's EHR was scanned into resident documents on [DATE], and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	matched the POLST found in R10's hard chart and hospice binder. HUC stated R10 had returned to the hospital a couple times after initial admission and that she was admitted from the hospital as DNR each time. HUC could not explain why there was a discrepancy with the POLST and orders in R10's EHR. During interview on [DATE] at 1:58 p.m., FM-A stated his understanding was that R10 was DNR and had been since entering hospice back in July of 2025. FM-A stated he had a health care directive for R10 before her cognitive decline which indicated she wanted to have a natural death. FM-A stated the social worker from hospice had tried to contact him, and he had not responded yet to her email or phone calls. FM-A stated he had a POLST form that he intended to have updated to reflect R10's wishes as DNR. During interview on [DATE] at 12:43 p.m., FM-B stated could not recall discussing or signing anything regarding R10's code status, but thought since R10 was on hospice, that meant they would not resuscitate and would allow a natural death. During interview on [DATE] at 12:54 p.m., RN-C state R10's POLST should have been reviewed and updated if needed when R10 signed onto hospice services. RN-C further stated code status should be reflected accurately throughout the resident's recorder-paper or electronic, to ensure the resident would receive their desired care in the case they were found unresponsive. During interview on [DATE] at 1:38 p.m., hospice nurse (RN-D) stated her understanding was that R10 was DNR and could not explain why the POLST in the hospice binder did not reflect that. RN-D further stated hospice social worker (SS-B) had discovered the discrepancy a while ago and had been attempting to reconcile it with FM-A for a few months. During interview on [DATE] at 1:50 p.m., SS-B stated had first reached out to FM-A regarding R10's POLST on [DATE] and requested to meet to review and update it. SS-B stated had visited R10 again [DATE] and [DATE] and both times attempted to contact FM-A about the POLST. SS-B stated understanding R10 had been DNR since admission to hospice and could not explain why the discrepancy had not been discovered or addressed before February. SS-B stated FM-A had not responded and agreed it was important to be taken care of as soon as possible. During follow up interview on [DATE] at 10:37 a.m., RN-C stated she was unaware of the discrepancy in the POLST document in R10's hospice chart and her provider orders prior to surveyor discovery on [DATE]. RN-C stated would have expected SS-B to have notified her as soon as it was discovered, so that the facility staff could have assisted in resolving the discrepancy. During interview on [DATE] at 1:43 p.m., director of nursing (DON) stated the POLST should match the documentation in the residents EHR. DON further stated that the provider was responsible for ensuring the completion and accuracy of the resident's POLST. DON stated that in R10's case, hospice would be considered the provider, and they should have reviewed R10's POLST upon admission to hospice and ensured an updated and accurate copy was in her hospice chart. DON further stated he was unaware until recently that there was a discrepancy and that SS-B had been working to resolve it. DON stated would have expected SS-B to notify the facility as soon as the discrepancy was discovered so that facility could assist and expedite to resolve the concern. Facility policy Hospice dated [DATE], indicated the facility's interdisciplinary team should collaborate and communicate with hospice representatives to ensure appropriate hospice care planning and quality of care for the resident and family.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to follow up on a 1 of 1 resident (R45) who glasses were broken. Findings include: R45's quarterly Minimum Data Set (MDS) dated [DATE], indicated severely impaired cognition and diagnoses of dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities), and Type II diabetes, and Parkinson's disease (progressive neurological disorder that primarily affects movement). It further indicated he was dependent on staff for most activities of daily living (ADL). R45's eye consult dated 6/3/25, indicated R45 should continue with the same eyeglasses and encourage full time use for distance and reading. R45's medical record lacked documentation regarding R45 glasses being broken or what was being done about it. During observation and interview on 4/13/26 at 1:57 p.m., R45 was in his room, sitting in his wheelchair. He stated he turned in his glasses because they were broken, and he still hasn't gotten them back. R45 was not wearing glasses, nor were they in his room. During interview on 4/16/26 at 9:23 a.m., nursing assistant (NA)-D stated R45 had glasses, but they broke about a month ago, so he hasn't been wearing them. NA-D stated she told the supervisor (RN-C) about it. During interview on 4/16/26 at 9:33 a.m., registered nurse (RN)-C verified R45 wears glasses and they were broken. RN-C was unsure as to how long they have been broken but social services (SS)-A was aware of it because the nursing assistant told them and gave them the broken glasses. During interview on 4/16/26 at 1:44 p.m., SS-A stated he was aware of R45 glasses being broken and would need to look and see when it happened and for any documentation regarding whether or not new glasses had been ordered or where they were in the process. SS-A never got back to the surveyor and no additional information was sent. A policy regarding social services dated 11/28/17, indicated the resident received care and services to assists them in reaching and maintaining their highest level of mental and psychosocial functioning which includes speech, language, vision, and hearing issues.

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	245310	A. Building B. Wing	04/16/2026

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Benedictine Health Center Innsbruck	1101 Black Oak Drive New Brighton, MN 55112

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure fall interventions were in place for 1 of 2 residents (R10) reviewed for falls. Findings include:R10's quarterly Minimum Data Set (MDS) dated [DATE], R10 had severe cognitive impairment, required substantial to maximal assistance for most activities of daily living (ADLs) and mobility. The MDS further indicated that R10 had two or more falls without injury and one fall with injury since admission. The MDS indicated R10 did not exhibit rejection of care behavior. R10's diagnoses included dementia and history of fracture of right leg. R10's care plan dated 1/28/26, indicated R10 had self-care deficit in mobility and was at risk for falls. R10's care plan identified interventions included hip protectors on at all times to prevent further injuries, floor mat beside the bed, and call light in reach at all times when in room. During observation on 4/16/26 at 8:13 a.m., R10 was asleep in bed asleep. The bed was in a low position. The mat was folded and stored in the corner of the room and was not on the floor next to the bed. The call light was on the floor next to the bed. During observation and interview on 4/16/26 at 8:53 a.m., nursing assistant (NA)-C stated R10 was at risk for falls and was supposed to wear hip protectors all the time but did not like them and refused them at times. NA-C further stated additional interventions included low bed, mat on floor and call light in reach. NA-C went into R10's room and verified R10 did not have hip protectors on, mat was not on the floor by the bed and call light was on the floor and not in reach. NA-C stated that without the hip protectors on, it was very important all the other intervention were in place to prevent a fall and any injury from fall if it occurred. During interview on 4/16/26 at 9:09 a.m., licensed practical nurse (LPN)-B stated R10 was supposed to wear hip protectors but did have the right to refuse. LPN-B further stated R10 should also have a mat on the floor next to the bed whenever she was in bed especially if she refused the hip protectors. During interview on 4/16/26 at 10:37 a.m., registered nurse (RN)-C stated R10's fall interventions included hip protectors, call light in reach and mat on floor when in bed. RN-C further stated any refusals to wear the hip protector should be documented.During interview on 4/16/26 at 1:43 p.m., director of nursing (DON) expected falls interventions to be in place and would expect R10 to have hip protectors on unless refused. If R10 refused, it should be documented. DON stated R10 should also have a mat next to the bed whenever she was in bed. Facility policy Integrated Fall Management dated 9/2023, indicated, Fall risk assessment, identification and implementation of appropriate interventions as necessary, to maintain resident safety, prevent falls and reduce further injury from falls.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure oxygen therapy was administered and maintained for 2 of 2 residents (R49, R9) reviewed for respiratory therapy.Findings include:R49's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of acute respiratory failure with hypoxia (serious condition where the lungs cannot adequately supply oxygen to the blood, leading to low oxygen levels (hypoxemia) and potentially life-threatening complications), shortness of breath, and congestive heart failure (chronic condition where the heart is unable to pump blood effectively, leading to fluid buildup in the lungs and other body parts). R49's physician's orders dated 2/24/25, indicated continuous oxygen wean as able per nasal cannula to keep oxygen saturation greater than or equal to 90%. Current oxygen flow rate 2 liters per minute (LPM) every shift. R49's care plan dated 6/24/2024, indicated an alteration in respiratory status related to (pneumonia, respiratory Infection, chronic respiratory failure with hypoxia bronchitis, sleep apnea, and respiratory failure) as evidenced by (shortness of breath, abnormal lung sounds, oxygen use, Low oxygen saturation levels, and signs and symptoms respiratory distress. It further included the following interventions:-Resident will achieve oxygenation saturation percentage within normal limits and to keep oxygen saturation greater than or equal to 90%.-Administer nebulizers/inhalers as ordered-Auscultate lung sounds/breath sounds PRN-Avoid lying flat which causes Shortness of Breath-Cue/remind resident to rest when experiencing respiratory distress-Encourage compliance with 02. Ensure that portal oxygen is filled up Q shift.-Measure & document O2 saturation rates as needed-Observe for increased s/s of respiratory distress, change in LOC-Observe for side effects and the effectiveness of medications-Oxygen as ordered, fill the portable oxygen tank every shift-Update doctor or nurse practitioner on status as needed. During observation and interview on 4/13/26 at 4:52 p.m. R49 was in bed with continuous oxygen via nasal cannula. She stated her oxygen rate was supposed to be set at 2 LPM. Surveyor looked at her oxygen rate, and it was set to 3 LPM. During observation and interview on 4/15/26 at 8:25 a.m., nursing assistant (NA)-G and NA-A was assisting R49 to get up and ready for the day. R49 was in bed with continuous oxygen via nasal cannula. The oxygen rate was set at 3 LPM. NA-G verified it was set 3 LPM. During observation on 4/16/26 at 7:10 a.m., R49 was in bed sleeping with oxygen via nasal cannula set at 3 lpm. During observation and interview on 4/16/26 at 7:22 a.m., registered nurse (RN)-F verified R49's oxygen rate was set at 3 LPM and it should have been set at 2 LPM per doctor's orders. During interview on 4/16/26 at 9:43 a.m. registered nurse (RN)-C stated nurses were responsible for ensuring the residents oxygen rates were set according to the doctor's orders. If a resident requested their oxygen rate to be adjusted, the nurses were responsible for calling the physician and getting an order before adjusting the rate. During interview on 4/16/26 at 1:23 p.m. the director of nursing (DON) stated nurses were responsible (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for making sure the residents oxygen rate matches the physician's orders each shift and if the resident requests a change in the oxygen rate, they should be calling the physician and getting a new order. R9 R9's quarterly MDS dated [DATE], identified C9 had intact cognition and required partial to substantial assistance with most activities of daily living (ADLs). R9's diagnoses included chronic obstructive pulmonary disease (COPD) and acute and chronic respiratory failure with hypoxia. R9's nursing care sheet dated 4/10/26, indicated C9 required oxygen therapy at 2 liters per minute (lpm) using a nasal cannula. R9's provider orders indicated the following: -Oxygen Therapy.Oxygen liter flow: 2 liters. Start date 6/23/24 -Change nebulization tubing, humidifier, and oxygen tubing every Sunday and as needed. Start date 12/31/23. During observation on 4/13/26 at 12:16 p.m., R9 was in her room in a wheelchair, using a portable oxygen tank. R9's oxygen tubing did not have a label indicating when it was last changed. The liquid oxygen tank in the room had a humidifier which was labeled 1/26/26 AK. R9 stated the staff were not good at changing the tubing or humidifier and often said they could not find any to replace them with. During observation on 4/14/26 at 9:15 a.m., R9's oxygen tubing was unlabeled, and the humidifier was labeled 1/26/26. During observation and interview on 4/14/26 at 9:22 a.m., RN-A stated it was the nurses' responsibility to change oxygen tubing and humidifier weekly, and they should be labeled to identify when it was last changed. In R9's room, RN-A verified R9's oxygen tubing was unlabeled, and the humidifier was labeled 1/26/26. RN-A stated that date indicted the last time the humidifier was changed and not changing the humidifier and tubing timely could lead to respiratory infection. During interview on 4/15/26 at 12:54 p.m., RN-C stated oxygen tubing, and the humidifier should be changed weekly. RN-C stated a date of 1/26/26 on R9's humidifier indicated it had not been changed since then, and that not changing it could increase likelihood of R9 acquiring a respiratory infection. During interview on 4/16/26 at 1:43 p.m., director of nursing (DON) stated expectation for oxygen therapy to be maintained per provider orders and tubing/humidifier should be changed weekly. Facility policy Oxygen Therapy dated 5/28/24, indicated, Oxygen therapy is provided to residents in a safe manner as identified by a prescribed provider. Furthermore, the policy directed the staff should obtain physician orders for specifics regarding administration.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure medication orders were transcribed correctly (according to the physician orders) for 1 of 1 resident (R9) who was prescribed an antibiotic.Findings include: R9's quarterly Minimum Data Set (MDS) dated [DATE] indicated intact cognition and diagnosis of Prurigo nodularis (chronic skin condition characterized by intensely itchy, firm, raised nodules that often result from persistent scratching. R9's after visit summary dated 3/31/26, indicated a new order for Doxycycline 100 milligram (mg) capsule (antibiotic). Take 1 capsule (100 mg) by mouth two times daily for 10 days with meals. R9's physician's orders indicated to monitor adverse reaction to antibiotic every shift from 3/31/26-5/10/26.R9's care plan dated 4/15/26, indicated R45 was taking an antibiotic known as Doxycycline for Prurigo nodularis with an intervention to receive the antibiotic as ordered by the physician. R9's progress note dated 3/31/26, indicated R9 returned from a scheduled appointment with an order to start doxycycline 100 mg capsule twice a day for 10 days with meals. R9's medication administration record (MAR) from 4/1/26-4/15/26, indicated R9 had received doxycycline 100 mg, two times per day and on 4/16/26 had received doxycycline 100 mg, one time. According to the physician's orders, this medication should have been discontinued after 10 days (4/10/26). During interview on 4/13/2026 at 12:32 p.m., R9 stated she came back from a doctor's appointment on 3/31/26 with a new prescription for an antibiotic (Doxycycline) and she thought she was only supposed to take it for 10 days but was still receiving it. During interview on 4/16/26 at 9:33 a.m., registered nurse (RN)-C stated when a resident was going to an appointment, they would send a referral form with the resident and when they returned and had a new order, the doctor would write the order on the referral form and it would also be on the after visit summary. Then those new orders are entered into the computer by either a health unit coordinator (HUC) or a nurse. Then another nurse was required to verify those orders and if there were any inconsistencies, they should call the provider for clarification. The nurses were also expected to be documenting any medication changes in the progress notes, so everyone knows there was a change and the reason why it had changed. This process was important to ensure orders were entered correctly. RN-C verified R9 was only supposed to be taking Doxycycline for 10 days and was still receiving it even though it should have been discontinued. It had been entered to be discontinued on 5/10/26 instead of 4/10/26. During interview on 4/16/23 at approximately 10:00 a.m., the health unit coordinator (HUC) stated the process for entering new orders when a long-term care resident was admitted or came back from an appointment was for a nurse to enter in the orders and then another nurse was required to verify those orders. If the resident was not a long-term care resident, the process was for the HUC to enter in the orders and then a nurse was required to verify them. If there were any discrepancies, the nurse was required to call the provider for clarification. During interview on 4/16/26 at 1:23 a.m., the director of nursing (DON) stated the process for entering new orders when residents come back from appointments was for a nurse or HUC to enter the orders and then another nurse was required to verify those orders. If there was a discrepancy, the nurse would call the physician to clarify the order. The DON further stated, R35 came back from a doctor appt on 3/31/26, with new a new order for Doxycycline for 10 days and the staff made an error when entering the order and it was entered as being discontinued on 5/10/26 instead of 4/10/26. That was why they have two staff verifying the orders, in order to prevent mistakes like this. The managers should be double checking; these things have to be done. A facility policy regarding medication administration was requested and received but did not address transcribing orders.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure medication was discontinued according to physician's orders for 1 of 1 resident (R9) receiving an antibiotic. Furthermore, the facility failed to ensure side effect monitoring was in place for 1 of 1 resident (R35) receiving an anticoagulant (blood thinner). Findings include: R9R9's quarterly Minimum Data Set (MDS) dated [DATE] indicated intact cognition and diagnosis of Prurigo nodularis (chronic skin condition characterized by intensely itchy, firm, raised nodules that often result from persistent scratching. R9's after visit summary dated 3/31/26, indicated a new order for Doxycycline 100 milligram (mg) capsule. Take 1 capsule (100 mg) by mouth two times daily for 10 days with meals. R9's physician's orders indicated to monitor adverse reaction to antibiotic every shift from 3/31/26-5/10/26. R9's care plan dated 4/15/26, indicated R45 was taking an antibiotic known as Doxycycline for Prurigo nodularis with an intervention to receive the antibiotic as ordered by the physician. R9's progress note dated 3/31/26, indicated R9 returned from scheduled appointment with an order to start doxycycline 100 mg capsule twice a day for 10 days with meals. R9's medication administration record (MAR) from 4/1/26-4/15/26 indicated R9 had received doxycycline 100 mg, two times per day and on 4/16/26 had received doxycycline 100 mg, one time. According to the physician's orders, this medication should have been discontinued after 10 days (4/10/26). During interview on 4/13/2026 at 12:32 p.m., R9 stated she came back from a doctor's appointment on 3/31/26 with a new prescription for an antibiotic (Doxycycline) and she thought she was only supposed to take it for 10 days but was still receiving it. During interview on 4/16/26 at 9:33 a.m., registered nurse (RN)-C stated when a resident was going to an appointment, they would send a referral form with the resident and when they returned and had a new order, the doctor would write the order on the referral form and it would also be on the after visit summary. Then those new orders are entered into the computer by either a health unit coordinator (HUC) or a nurse. Then another nurse was required to verify those orders and if there were any inconsistencies, they should call the provider for clarification. The nurses were also expected to be documenting any medication changes in the progress notes, so everyone knows there was a change and the reason why it had changed. This process was important to ensure they are catching any mistakes. RN-C verified R9 was only supposed to be taking Doxycycline for 10 days and was still receiving it even though it should have been discontinued. It had been accidentally entered to be discontinued on 5/10/26 instead of 4/10/26. R35 R35's quarterly Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognition and diagnoses of congestive heart failure (when the heart is not pumping as well as it should) and atrial fibrillation (an irregular and often very rapid heart rhythm). It further indicated she received an anticoagulant on a routine basis. R35's physician's orders dated 4/9/26-4/22/26, indicated the following:-Warfarin tablet 2 milligrams (mg) oral. Once a day on Monday, Tuesday, Wednesday, and Friday.-Warfarin tablet 3 mg oral. Once a day on Sunday, Thursday, and Saturday. R35's medication administration record (MAR) and treatment administration record (TAR) from 4/1/26-4/15/26, lacked documentation of anticoagulation monitoring. R35's care plan dated 3/12/24, lacked indication of anticoagulation monitoring. During interview on 4/16/26 at 7:22 a.m., registered nurse (RN)-F verified R35 was receiving an anticoagulant medication (Warfarin) but was unable to find an order or documentation she was receiving anticoagulant monitoring (side effects such as bleeding, bruising, etc.) and should have been. During interview on 4/16/26 at 9:33 a.m., registered nurse (RN)-C stated residents receiving an anticoagulant should also have anticoagulation monitoring in place. This monitoring would be documented in the MAR or the care plan. RN-C further stated anticoagulation monitoring was important in order to ensure the resident did not have internal bleeding and to determine if the medication was working. During interview on 4/16/26 at 1:23 a.m., the director of nursing stated the process for entering new orders when residents come back from appointments was for a nurse or HUC to enter the orders and then another (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse was required to verify those orders. If there was a discrepancy, the nurses should be calling the physician to clarify the order. The DON further stated, R35 came back from a doctor appt on 3/31/26, with new a new order for Doxycycline for 10 days and the staff made an error when entering the order and it was entered as being discontinued on 5/10/26 instead of 4/10/26. That was why they have two staff verifying the orders, in order to prevent mistakes like this. Additionally, the DON stated residents taking an anticoagulant should have anticoagulant monitoring in place. R35 had gone to the hospital, and the overnight nurse accidentally discontinued the order for anticoagulation monitoring. The managers should be double checking; these things have to be done. A facility policy regarding medication administration dated 8/31/23, indicated medications will be administered in accordance with the doctor's orders. The policy did not address anticoagulation monitoring.