STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245236	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Health Center	935 Kenwood Avenue Duluth, MN 55811

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to report an injury of unknown origin to the State Agency (SA) immediately, but not later than two hours, for 1 of 4 (R1) residents reviewed for resident safety. Findings include: On 5/12/25 at 12:30 p.m. a facility reported incident (FRI) submitted to the SA by the facility administrator indicated on 5/11/25, at 4:00 a.m. R1 had a new bruise to her right under arm. R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had diagnoses of stroke, hemiplegia and hemiparesis (paralysis) of her right dominant side, and impaired cognition following cerebral infarction (stroke). The MDS indicated R1 had moderate cognitive impairment and required extensive assistance by staff for bed mobility and transfers. The MDS further indicated R1 was taking anticoagulant and antiplatelet medications (both medications prevent blood from clotting). R1's care plan dated 5/8/25 directed two staff to assist with transfers, using a mechanical lift. The care plan directed 1-2 staff to assist with bed mobility. R1's care plan directed staff to investigate any allegations of suspected abuse, neglect, or exploitation. R1's skin check assessment dated [DATE] lacked indication of bruising. On 5/11/25 at 5:12 a.m. a progress note indicated R1's right arm had fresh swelling and bruising, from armpit to just above her elbow. Swelling included entire length of arm. R1 denied an injury, and stated she could not recall if her arm had been injured. On 5/11/25 at 12:20 p.m. a progress note indicated R1 had a large bruise of her right upper arm with swelling from shoulder throughout arm, hand, and fingertips. R1 was unable to raise her right arm. Bruise of lateral side of right breast outlined, and R1 reported subtle pain of area only when palpated. Surface over front of shoulder was hard and raised. R1 reported tenderness to site when palpated. The on-call nurse was informed. Bruise measured 15.1 centimeters (cm) x 18.8 cm. On-call provider notified. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/12/25 at 10:14 a.m. a progress note indicated R1 had extensive dark bruising on her right breast, and right arm from elbow to shoulder. R1's upper chest/collarbone on the right side were not bruised, but very swollen and firm. R1 denied injury of any kind. Provider updated and ordered R1 be sent to the emergency room. On 5/13/25 at 9:30 a.m. a progress note indicated R1 reported to the hospital the cause of her injury was a fall on Thursday (5/8/25) and a transfer on Friday (5/9/25) that went bad, and she also asked staff if the devil did this to her. R1 did not have dementia and experienced forgetfulness and confusion at baseline. On 5/15/25 at 12:03 p.m. R1 stated, The hospital told me I got beat up, but she was unable to identify whom may have hurt her. R1 then denied anyone hurt her, denied any falls, and stated she just woke up with the bruises to her right arm. During an observation on 5/15/25 at 12:05 p.m. R1's right upper arm had discoloration extending from the armpit throughout the lower arm and hand on the medial (side closest to the body) side, which ranged in color from dark to light purple, with some shades of yellowish green. On 5/15/25 at 1:05 p.m. registered nurse (RN)-A stated R1's bruising was first noticed on 5/11/25 at 5:00 a.m. , but not reported to the SA until 5/12/25. She first saw R1's bruise on 5/12/25. Most of the bruise was a deep dark purple at that time. The injury was reported to the nurse on-call on 5/11/25. The injury should have been reported to the SA within one hour. On 5/15/25 at 1:26 p.m. trained medication aide (TMA)-A stated he notified the on-call nurse of R1's bruise on 5/11/25 around 11:00 a.m. On 5/15/25 at 1:38 p.m. licensed practical nurse (LPN)-A stated TMA-A notified the on-call nurse of R1's bruise on 5/11/25. The policy was to notify the on-call nurse right away, and follow directions when there was a new bruise or injury. On 5/15/25 at 1:57 p.m. LPN-B stated she was the on-call nurse on 5/11/25. She was informed of R1's bruise by TMA-A on 5/11/25 at 11:55 a.m. She did not remember if she instructed TMA-A to inform the director of nursing (DON) of R1's bruise. The policy was to notify the administrator, DON, provider, and family when there was a injury of unknown source. The SA was to be notified within 24 hours. On 5/15/25 at 2:32 p.m. the administrator stated she was informed of R1's bruise on the morning of 5/12/25. The administrator stated she filed the report with the SA on 5/12/25. The administrator stated immediate education was provided to staff to report injuries of unknown origin immediately. The facility Abuse Prevention Plan dated 7/22 identified an injury should be classified as an injury of unknown source when both of the following criteria are met: 1) The source of the injury was not observed by any person or the source of the injury could not be explained; and 2) The injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time of the incidence of injuries over time. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy directed if the event that caused the suspicion involves abuse or results in serious bodily injury, the individual is required to report the suspicion to the state immediately, but not later than 2 hours, after forming the suspicion. If the event does not involve abuse and does not result in bodily injury, the individual is required to report to the state no later than 24 hours after form the suspicion.