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	11/25/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 1 of 1 resident (R1) was free from sexual abuse when nursing assistant (NA)-A entered R1's room with his genitals exposed to R1 and proceeded to hold R1's hand while holding his genitals in his other hand. This had the potential to result in serious psychosocial harm for R1.The IJ began on 10/22/25, at approximately 5:00 a.m., when NA-A entered R1's room and sexually abused R1. NA-A exposed his genitals to R1 through his unzipped pants and held R1's hand with one hand while holding his genitals in his other hand. The administrator and the director of nursing (DON) were informed of the IJ on 10/29/25, at 3:36 p.m. The facility had implemented corrective action to prevent recurrence by 10/22/25, therefore, F600 is being issued at past non-compliance. Findings include:R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact. Diagnoses included hemiplegia (paralysis or weakness of one side of the body), dysphagia (difficulty swallowing), and aphasia (difficulty with communication).R1's care plan dated 10/22/25, identified R1 was vulnerable to abuse from others and needed assistance to remain safe in the facility. The care plan also indicated R1 believed sexual trauma had been experienced. R1's vulnerabilities included physical limitations, hemiplegia and hemiparesis after a stroke, and communication deficitsA Nursing Home Incident Report to the State Agency (SA) dated 10/22/25, identified R1 had reported to licensed practical nurse (LPN)-A, that NA-A had placed R1's hand on or around NA-A's genital region.The facility investigation file indicated NA-A was interviewed by the director of nursing (DON) on 10/27/25 at 8:33 a.m. During the interview NA-A told the DON between 5:15 a.m. and 5:30 a.m., he had gone into R1's room to empty the catheter bag. NA-A's genitals were outside of his pants. He went up and said goodbye to R1 while holding R1's hand in one hand and his exposed genitals in the other hand. The file indicated NA-A reported R1's hand did not touch his genitals while out of his unzipped pants.During an interview on 10/29/25 at 9:03 a.m., communicating via a letter board, R1 identified that NA-A came into the room on the morning of 10/22/25 and his pants were unzipped. NA-A's genitals were exposed outside of the zipper where R1 could see it. NA-A then grabbed R1's hand and held it around NA-A's genital region and skin to skin contact was made. R1 was tearful as she spelled out the answers to the questions. The interview was assisted by LPN-A, who also confirmed the understanding of what R1 was communicating.During an interview on 10/29/25 at 9:25 a.m., LPN-A stated R1 had reported the initial concerns to him. LPN-A stated he could tell there were issues with R1 and asked if something was wrong. R1 shook her head yes. LPN-A asked if there was a staff issue and R1 proceeded to spell out the word report. When asked if R1 wanted to report a staff member R1 shook her head yes. LPN-A proceeded to leave R1's room and went to the nurse manager. LPN-A, registered nurse (RN-A) and the social services designee (SSD) all went into R1's room together. RN-A asked R1 what was wrong and R1 spelled out zipper. LPN-A stated after hearing the word zipper he stepped out of the room.On 10/29/25, RN-A was on vacation and unable to be interviewed.During an interview on 10:29 a.m., SSD stated LPN-A, RN-A and the SSD went into R1's room to talk about what needed to be reported. RN-A asked R1 what was wrong and R1 spelled out the word zipper. R1 reported she had been (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	inappropriately touched by NA-A during cares. SSD stated R1 reported NA-A physically moved the hand to make contact with NA-A's genitals. NA-A was not clothed and skin to skin contact had happened. R1 had also reported to SSD NA-A had used her hand to touch and perform sexual acts with his genitalia but penetration had not occurred. R1 was tearful throughout the entire interview.During an interview on 10/29/25 at 12:46 p.m., the DON stated everything happened on 10/22/25 around 5:15 a.m. The incident was reported as soon as he found out about it. All staff reported they did not go in the room with NA-A, but review of the cameras confirmed NA-A had entered R1's room around 5:15 a.m. on 10/22/25. The DON confirmed NA-A reported the genitals were outside his unzipped pants and that he had held R1's hand while holding his genitals outside of his pants with NA-A's other hand. NA-A reported he did not touch his genitals with R1's hand.During an interview on 10/30/25 at 8:30 a.m., NA-A stated he had entered R1's room on 10/22/25 at approximately 5:15 a.m. His genitals were exposed to R1 outside his pants when entering the room. NA-A then proceeded to hold his genitals on one hand while grabbing R1's hand with NA-A's empty hand. NA-A did not touch his genitals with R1's hand.The facility's Abuse Prevention Plan last revised 7/21/22, indicated the definition of abuse included the willful infliction of unreasonable confinement, intimidation or punishment of which resulted in physical harm, pain or mental anguish. This included sexual and mental abuse. Sexual abuse was defined as the non-consensual sexual contact of any type with a resident.The past noncompliance IJ began on 10/22/25. The IJ was removed and the deficient practice corrected on 10/22/25, when NA-A was suspended and later resigned. The facility conducted an investigation which included other resident interviews and staff interviews (no further incidents of abuse were found), and re-training was completed at that time for all staff related to abuse and was confirmed through review of education and signed attendance sheets showing all staff received training. The abuse policy was also reviewed as part of the investigation.