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	12/19/2025

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

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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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure infection control interventions were implemented during an outbreak of SARS-CoV-2 (COVID), according to nationally recognized standards of practice such as Centers for Disease Control and Prevention (CDC) guidelines, including contact tracing and testing of staff and residents per guidelines. In addition, the facility staff failed to utilize proper personal protective equipment (PPE) while caring for COVID-positive residents and ensure that equipment was properly sanitized following use in a COVID-positive resident room. The deficient practice resulted in an immediate jeopardy (IJ), when 19 of 96 residents (R72, R94, R65, R84, R31, R20, R41, R61, R69, R81, R13, R106, R109, R39, R64, R90, R29, R51, R110) tested positive for COVID, three of the COVID positive residents were subsequently hospitalized (R69, R72, R94) and 11 facility staff tested positive. In addition, the facility failed to ensure a resident catheter bag was appropriately concealed and not in contact with the floor for 1 of 1 resident (R5) reviewed for catheter cares.The immediate jeopardy began on 12/4/25, when appropriate infection control interventions, including contact tracing and testing of staff, were not implemented to reduce the spread of COVID in the facility. Further observations were completed and indicated that facility staff were not properly utilizing PPE while caring for COVID-positive residents or sanitizing reusable medical equipment after use with COVID-positive residents. The immediate jeopardy was identified on 12/17/25. The administrator, nurse consultant (NC)-B, and director of nursing (DON) were notified of the IJ at 6:00 p.m. on 12/17/25. The immediate jeopardy was removed on 12/17/25. However, non-compliance remained at a pattern scope and severity with potential for more than minimal harm that is not immediate jeopardy (level E). Findings include: The Centers for Disease Control and Prevention guidance titled Infection Control Guidance: SARS-CoV-2 (COVID) dated 6/24/24, indicated for nursing homes that if they had a single new case of COVID for any healthcare provider (HCP) or resident, it should be evaluated to determine if others in the facility have been exposed. The guidance indicated that the facility should approach the outbreak investigation with either contact tracing or use a broad-based approach. The guidance indicated that a broad-based approach was preferred if all potential contacts cannot be identified or managed with contact tracing, or if contact tracing failed to halt transmission. The guidance indicated COVID testing should be performed for all residents and HCPs identified as close contacts or on the affected unit(s) if using a broad-based approach. The guidance indicated testing should be completed for all residents and HCPs who had close contact or were on the affected unit immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. If additional cases are identified during contact tracing, strong consideration should be given to shifting to a broad-based approach if not already being performed. The guidance indicated broad-based testing should be continued on affected units or facility-wide, every three to seven days until there are no new cases for 14 days. (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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A memo (memorandum) dated 12/12/25, was addressed to skilled nursing facility associates, residents, and visitors. The memo indicated that the facility was experiencing an outbreak of COVID-19 on the third floor and that the facility was taking immediate steps to mitigate the spread of the virus. The memo indicated source control measures (surgical masks) were implemented throughout the third floor. The memo indicated masking would be implemented for all associates who work on the third floor, and residents would be encouraged to wear masks when they are outside their rooms. The memo indicated group activities, services, and communal dining would be limited during that time. The memo encouraged visitors to wear masks and practice good hand hygiene. A memo dated 12/15/25, was addressed to skilled nursing facility associates, residents, and visitors. The memo indicated that the facility was experiencing an outbreak of COVID-19 and was taking immediate steps to mitigate the spread of the virus. The memo indicated source control measures (surgical masks) were implemented throughout the facility. The memo indicated masking would be implemented for all associates, and residents would be encouraged to wear masks when they are outside their rooms. The memo indicated group activities, services, and communal dining would be limited during that time. The memo encouraged visitors to wear masks and practice good hand hygiene. Residents Who Tested Positive for COVID The Preventive Health Care Report dated 12/1/25 to 12/17/25, identified the following residents tested positive for COVID:- On 12/10/25, R72 on the third floor.- On 12/11/25, R94 on the third floor.- On 12/12/25, R65 on the third floor.- On 12/13/25, R84 on the third floor.- On 12/14/25, R31 on the second floor and R20, R41, and R61 on the third floor. - On 12/15/25, R69 and R81 on the second floor- On 12/16/25, R13, R106, R109, and R39 on the second floor and R64 and R90 on the third floor- R29, R51, and R110 were not included in the report. R29's progress note dated 12/13/25 at 11:03 p.m., identified R29 had tested positive for COVID. R29's face sheet dated 12/19/25, identified R29 resided on the third floor. R51's progress note dated 12/15/25 at 3:51 a.m., identified R51 had a moist cough with slight wheezing heard in the lungs bilaterally. The note indicated R51 was swabbed and tested positive for COVID. R51's face sheet dated 12/19/25, identified R51 resided on the third floor. R110's progress note dated 12/14/25 at 1:47 p.m., identified R110 had tested positive for COVID. R110's face sheet dated 12/19/25, identified R110 resided on the second floor. COVID Positive Residents hospitalized R69's progress notes included the following:-12/15/25 at 1:40 p.m., identified R69 had chills and increased confusion. R69 was tested for COVID and was positive. -12/15/25 at 11:55 p.m., identified R69 stated he did not feel well, had an occasional dry cough, and weakness/fatigue. The note indicated R69 also had increased confusion.-12/16/25 at 2:25 a.m., identified R69 was weak and could hardly get out of bed.-12/16/25 at 2:00 p.m., identified R69 was transferred to the hospital for increased delirium, four unwitnessed falls in the last 24 hours, weakness, and a COVID-positive (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	status. R69's face sheet dated 12/19/25, identified R69 was diagnosed with dementia, heart disease, and unspecified convulsions. R72's progress notes included the following:-12/10/25 at 8:07 p.m., identified when R72 had returned from dialysis (a medical treatment that filters blood when the kidneys fail), he had reported increased respiratory symptoms, shaking, chills, general malaise, fatigue, and reported not feeling well. R72 was found to be COVID-positive after testing. The note indicated R72 had several outside of the facility appointments in the recent past, and the facilities would be updated accordingly. The note indicated nursing leadership was notified, and R72's respiratory status had been quite compromised.-12/15/25 at 7:31 p.m., R72 stated he did not feel well and had increased shortness of breath. On assessment, R72 had extremely coarse lung sounds on the left side, and the provider was notified, who recommended the resident be admitted to the hospital. R72 eventually agreed to hospital admission and was sent to the hospital. R72's face sheet dated 12/19/25, identified R72 was diagnosed with kidney failure with a dependence on dialysis, heart failure, diabetes, and a heart arrhythmia (irregular heartbeat). R94's progress notes included the following:-12/11/25 at 1:16 p.m., identified R94 had tested positive for COVID.-12/15/25 at 11:04 a.m., identified R94 had an out of reference electrolyte imbalance with a critical low sodium level, and the resident was sent to the hospital for evaluation. -12/16/25 at 7:58 a.m., identified R94 was admitted to the hospital for a diagnosis of a low sodium level and pneumonia. R94's face sheet dated 12/19/25, identified R94 was diagnosed with acute transverse myelitis (inflammation of the spinal cord, which can cause loss of sensation, movement, and bladder control), vomiting/diarrhea, and malnutrition. Employees Who Tested Positive for COVID Employee Information Line Listing dated 12/17/25, identified the following:-Cook (C)-A had a positive COVID test on 12/4/25.-Nursing assistant (NA)-A had a positive COVID test on 12/11/25 and last worked on 12/10/25. The listing indicated NA-A became symptomatic on 12/11/25 and reported the illness on 12/15/25. Per an email on 12/16/25 at 3:31 p.m., when asked what department COVID-positive staff members worked for, the administrator indicated NA-A worked on the third floor. -Dietary aide (DA)-B had a positive COVID test on 12/13/25.-Registered nurse (RN)-A had a positive COVID test on 12/14/25.-RN-B had a positive COVID test on 12/15/25.-Unknown department supervisor (ADS) had a positive COVID test on 12/15/25.-DA-A had a positive COVID test on 12/15/25.-NA-B had a positive COVID test on 12/15/25.-NA-C had a positive COVID test on 12/15/25.-RN-C was reported to have COVID on 12/15/25, but the listing did not indicate what date RN-C tested positive.-laundry aide (LA)-A had a positive COVID test on 12/17/25. Staff Interviews During an interview on 12/17/25 at 9:13 a.m. with the infection preventionist (IP)-C (a registered nurse) and licensed practical nurse (LPN)-A:-The IP-C stated C-A had tested positive on 12/4/25. IP-C stated she would have expected the culinary director to complete symptom screening with the staff members who were in close contact with (C)-A, but she did not believe any testing or anything formally was completed after (C)-A had tested positive on 12/4/25. The IP-C stated she would have (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	to check with the culinary director, who was out sick with COVID, to see if any further infection control measures were taken in the kitchen with this incident of COVID. -The IP-C stated the first positive resident case of this outbreak in the facility had been on 12/10/25 and was R72. LPN-A stated R72 frequently had appointments outside of the facility, including dialysis, but was isolated to his room while at the facility. IP-C stated she had decided to complete contract tracing with symptom-based testing, so testing was only completed for residents or staff members who had symptoms of COVID. IP-C stated that contact tracing had been completed after R72 tested positive, but she did not keep records of this contact tracing. LPN-A stated R72's health had been very compromised before contracting COVID and confirmed R72 resided on the third floor. LPN-A stated no other residents were in close contact with R72. IP-C stated she would have to consult the staff schedule to see what staff members would have been in close contact with the resident. The IP-C stated all staff members in close contact with R72 had been notified of their contact, but she thought testing had only been completed if staff members had symptoms of COVID. The IP-C stated she only had a record of staff testing if the results of the test were positive for COVID. The IP-C stated she was unsure off the top of her head how often serial testing would have been completed for staff members. The IP-C confirmed that serial testing had not been occurring for residents and staff members who didn't have symptoms of COVID, as symptom-based testing was occurring.-The IP-C stated the second staff member to test positive for COVID during this outbreak was DA-B on 12/13/25, who worked in the dietary department. The IP-C stated she would again have to check with the culinary director to see if contact tracing had been completed but believed it had been. The IP-C stated the next staff COVID case was RN-A on 12/14/25, and she believed NA-A tested positive on 12/15/25. -The IP-C confirmed R94, who resided on the third floor, had tested positive for COVID on 12/11/25. The IP-C confirmed R65, who resided on the third floor, had tested positive for COVID on 12/12/25. At 9:46 a.m., the director of nursing (DON) entered the conversation. The IP-C stated she believed that they recognized the facility had an outbreak on the third floor on 12/12/25 and sent out a memo to residents, staff, and visitors. All 13 total positive resident cases (R72, R94, R65, R84, R29, R20, R61, R41, R31, R110, R51, R81, R69) from 12/10/25 to 12/15/25 were reviewed with the IP-C. The IP-C stated at that time the facility continued to complete contact-based tracking and testing, as they did after R72 tested positive for COVID until 12/14/25, when they had the first case on the second floor, as all prior cases were on the third floor. The IP-C stated they declared a facility-wide outbreak on 12/14/25 and started facility-wide testing on 12/16/25. The IP-C stated that after all staff and resident cases until 12/14/25, they had completed contact tracing and completed symptom-based testing but would have to check with other staff members to see if they kept records of this contact tracing. The IP-C stated she would have preferred facility-wide COVID testing be started on 12/15/25, but due to time limitations caused by the recertification survey, that did not happen. -The LPN-A stated that three residents who had a diagnosis of active COVID had been admitted to the hospital. LPN-A stated R94 had been admitted to the hospital with critical labs and was diagnosed with pneumonia. LPN-A stated R72 had a history of pleural effusions and had been hospitalized for this recurring condition. LPN-A stated R69 had also been hospitalized , but she was not sure what for. During an interview on 12/17/25 at 10:56 a.m., housekeeper (HK)-A stated this morning was the first time she had been tested during this outbreak and had previously been told she would need to test if she was symptomatic. HK-A added that if there were an outbreak, they would be notified by email, and she did get that email yesterday. During an interview on 12/17/25 at 10:59 a.m., NA-F stated she tested yesterday or Monday, but hadn't tested yet today. NA-F provided she only worked on this unit, and it didn't have any COVID, but she did know there was an outbreak, and she needed to wear a mask. NA-F added there was a self-testing station in the education room, which was always there for self-testing, and then staff would write in the logbook. NA-F stated she had received an email (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's COVID-19 Policy Manual dated 11/13/25, indicated under the heading Symptom and Contact-Based Testing that residents and staff members who develop COVID symptoms, had close contact (within six feet of positive person for greater than or equal to 15 minutes over a 24 hour period), or had a higher-risk exposure where the eyes, nose, or mouth were exposed to material potentially containing COVID should be tested for COVID. The manual then had a heading titled Outbreak Investigation Testing with instructions to implement when one resident or staff member had newly tested positive and was in the community during the infectious period. The manual indicated the facility had three options for how to conduct outbreak testing:-contract tracing testing where all staff members who had a higher risk exposure with a COVID-positive individual, and all residents who had close contact with a COVID-positive individual were tested.-Unit-based testing where all staff and residents were tested based on assignment and locations-facility-wide testing where all staff members and residents at the facility were tested. The policy then indicates if positive results were confirmed, continue bi-weekly testing of all previously negative residents and staff based on the outbreak testing option chosen until there were no new cases for at least 14 days. The policy indicated that if contact-based testing was being utilized, testing was recommended immediately (but not earlier than 24 hours after exposure) and if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day zero), day three, and day five. A complete list of all residents and staff members who tested positive during the covid outbreak as of 12/19/25 was requested and not received. Infection Control Observations R69's Face sheet no date, identified R69 had diagnoses which included convulsions, dementia, hypertension, hyperlipidemia, anxiety, insomnia, pain, depression, and difficulty walking. R69's quarterly MDS dated [DATE], identified he was usually understood and was able to understand, was moderately cognitively intact, and was independent with activities of daily living. R69's nursing notes dated 12/17/25 at 4:55 p.m., identified R69 tested positive for COVID 19 on 12/15/25. During an observation on 12/16/25 at 12:04 p.m., NA-D donned personal protective equipment (PPE) and entered R69's room with a vital sign machine. Affixed to R69's door was a droplet/contact precautions sign due to R69's COVID positive status. On 12/16/25 at 12:06 p.m., NA-D exited R69's room and brought the vital sign machine to a spot near the medication cart. During an interview on 12/16/25 at 12:14 p.m., NA-D verified she did not sanitize the vital sign machine after leaving R69's room. During an interview on 12/18/25 at 12:52 p.m., the DON verified equipment brought into isolation rooms (droplet/contact) should absolutely be sanitized to prevent any transmission of virus or bug. Resident Care Equipment dated 6/2017, identified Each community will protect against indirect transmission, which is the transfer of an infectious agent through a contaminated intermediate object, through decontamination of an object rendering it safe to use. In addition, the policy identified as a (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	currently had 4 staff members out with COVID-19. The immediate jeopardy that began on 12/4/25, was removed on 12/17/25 when the facility implemented an infection control plan to minimize the spread of COVID, which included resident COVID testing twice a week or if having symptoms, all staff COVID tested before their shifts, and sanitizing all shared resident equipment. Staff were provided education regarding the infection control procedures, such as COVID testing protocols, PPE use, and sanitizing shared equipment. Catheter Observation R5's quarterly Minimum data set (MDS) dated [DATE], indicated R5 was cognitively intact with the diagnoses of chronic respiratory failure with hypoxia, obstructive and reflux uropathy and urine retention. The undated, facility provided document titled Observation Detail Report identified R5 had an indwelling catheter. The note section dated 6/3/25, identified R5 had a history of urinary tract infections, but had not had one in the last 30 days. A 11/21/25, note indicated R5's catheter was in place due to obstructive and reflux uropathy with urinary retention. Daily and PRN catheter care was being done along with monthly catheter changes. R5's Care plan last updated on 12/15/25, identified R5 as being on enhanced barrier precautions to minimize the risks of/and prevention of infections related to their indwelling catheter. R5's Physician Order Report: 6/10/25 to 12/19/25, identified an order: per urology change catheter every four to six weeks, once a day on the 20th of every month. R5's Medication and Treatment record dated 12/1/25 to 12/19/25, included documented entries of routine Foley care completion each shift. During an observation on 12/15/25 at 3:30 p.m., R5 was in bed. R5's catheter bag was directly on the floor by the foot of the bed on R25's left side. R25's shared bathroom had an unlabeled graduated cylinder sitting on back of toilet below the flush handle. Two bins were stacked on the floor between the wall and the toilet with an unlabeled bedside urinal in one of the bins. During an observation on 12/16/25 at 3:10 p.m., R5 was in bed. their catheter bag was located in the same place directly on the floor. The blue drainage spout was in direct contact with the floor. During an observation on 12/17/25 at 2:25 p.m., R5 was in bed, their catheter bag was directly on the floor in the same location as before. During an interview on 12/19/25 at 9:05 a.m., registered nurse (RN-E) stated she had just been in R5's room and RN-E confirmed R5's catheter bag had been directly on the floor at the foot of R5's bed. RN-E stated R5's catheter bag should not be on the floor because of the risk for contamination which put R5 at a higher risk for infection. RN-E stated they would be placing R5's catheter bag in a dignity bag for cleanliness/infection prevention and resident dignity. During an observation on 9/19/25 at 9:20 a.m., R5's catheter bag was at the left foot of the bed directly on the floor. (continued on next page)

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Benedictine Health Center	935 Kenwood Avenue Duluth, MN 55811

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 12/19/2025 at 9:52 a.m., the director of nursing (DON) stated catheter bags should be concealed in a dignity bag and attached to the bed or chair at a level below the bladder. As an infection prevention measure, catheter bags should not be directly on the floor due to the risk of contamination from contact with the floor. The facility policy Prevention of Catheter-Associated Urinary Tract Infections (CAUTI) dated 2017, identified complications associated with CAUTI could result in resident decline in function and mobility, hospitalizations, and increased mortality, prevention is key. The policy instructed to ensure the catheter bag was always hanging below the bladder and not to touch the catheter drainage bag with the collection container when emptying the catheter. The peri-urethra should be cleaned regularly with mild soap and water and then rinsed. The policy did not address catheter contact with the floor or other potentially contaminated objects or surfaces.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure the proper labeling of medications and the removal of expired medications and supplies occurred in two of two medication rooms and 3 of 6 medication carts. This deficient practice had the potential to impact all residents who received supplies and medications from reviewed medication rooms and carts.Findings include:During a medication pass observation on 12/17/25 at 7:36 a.m., trained medication administrator (TMA-B) pulled medications for administration to R21. Medications included Mucinex. TMA-B reviewed the Mucinex box they had pulled for administration and confirmed the Mucinex had expired. TMA-A stated the medication should have been pulled from the cart when it expired. TMA-A removed the box and then administered R21 Mucinex from a non-expired medication card.The third-floor medication cart identified as norther lights cart was reviewed on 12/17/2025 at 9:32 a.m., with licensed practical nurse (LPN-B). LPN-B confirmed the following findings: Drawer one contained an insulin syringe which had been opened but not dated. A second insulin pen wad dated, but the date was unreadable. Drawer two contained a stock medication acid reducer famotidine, expiration date July 2025. Drawer four contained a discharged resident's inhaler and a box of expired Mucinex. LPN-B pulled the expired medications from the cart for disposal. LPN-B stated medications like insulin, inhalers and eye drops needed to be dated when opened because the expiration date of the medication changed when it was opened. The expired medications should have been pulled from the cart when the medications expired.A partial review of the third-floor medication room was completed on 12/17/25 at 9:40 with LPN-B. Expired insulin syringes and 3 sets of expired blood culture bottles were found in the medication room. During a follow-up review of the third-floor medication room on 12/17/25 at 10:59 a.m., the director of nursing (DON) confirmed two partial boxes of 100-unit insulin syringes had expired on 9/20/25. The DON removed the supplies from the medication room and stated they expected staff to be checking dates on supplies and medications and removing them from stock when expired. A review of the 2nd floor medication room and blood draw supply was completed on 12/17/25 at 10:16 a.m., with the director of nursing DON. The DON confirmed and removed a box of safety needles that had expired on 2/28/25. The DON confirmed and removed the following expired resident labeled supplies from the intravenous supply cart: two expired central line dressing kits, several expired iv positive pressure caps, multiple expired picc plus stat locks, and expired guardiva dressings. The DON stated the supplies belonged to a resident who had been discharged . The DON confirmed the lab cart in the lab storage area was used by facility staff to draw labs at the facility. The supplies were also used by one of the hospitals that drew labs at the facility as well. The DON performed an expiration date spot-check of lab tubes on the cart and confirmed approximately 25 tubes had expired between the dates of 6/30/25 and 10/31/25. The DON then reviewed the supply cabinet and found multiple green top tubes had expired on 10/31/25, and two partially full packs of yellow top tubes had expired on 11/30/25. The DON removed the expired lab tubes from supply and stated they would expect staff to routinely review and remove expired lab supplies from carts and storage areas to prevent the use of expired supplies on patients. The DON confirmed it was the responsibility of the facility to order lab supplies. The third-floor medication cart identified as Superior Waters was reviewed on 12/17/25 at approximately 11:30a.m., with TMA-B. TMA-B confirmed the following findings. The cart contained expired insulin syringes, and the following current resident expired medications: hydrochloride cream expired 11/2025, nystatin power expired 11/2024, two hydrocortisone creams expired 1/2025 and 11/2025, and an open bottle of nitroglycerin 0.5 mg labeled discard after 3/18/25. The cart also contained one partially used Ozempic pen and one glargine insulin pen. Both pens were not labeled with the date first opened. TMA-B stated expired medications should be removed from the cart. They did not give insulin as a TMA, but they knew (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications like insulin, inhalers, and eye drops were supposed to be labeled with the date when they were opened.A second-floor medication cart review was completed on 12/18/25 at 12:27 p.m., with registered nurse (RN-E). Cart drawer four contained medications of a resident who had been discharged from the facility on 12/1/25. There was also a current resident's inhaler that had been opened but not dated. RN-E stated things like inhalers and eye drops should be dated when opened. RN-E reviewed the fill date and admit date for the resident and dated the inhaler. RN-E stated it was the responsibility of everyone on the cart to make sure medications were labeled correctly, not expired, and for current residents only.During an interview on 12/18/25 at 1:30 p.m., LPN-A stated RN-E was the point person for medication rooms and medication carts. They believed RN-E performed outdate audits and so did the consulting pharmacy service. Beyond that it was a shared responsibility of anyone working on the cart to make sure that discharged resident's medications and expired medications/supplies were pulled from carts and medication rooms. LPN-A confirmed insulin pens, eye drops, and inhalers should be labeled with the date opened. During an interview on 12/19/2025 at 8:57 a.m., the DON stated they expected only properly labeled current resident non-expired medications and supplies to be stored in medication carts and med rooms. Carts and med rooms should be checked by staff for expired medications and supplies, and proper labeling throughout the work shift. Expired and discharged patient medications/supplies should be removed for proper disposal when found. The facility policy Medication Storage in the Facility Storage of Medications dated 3/17, directed outdated medications are to be immediately removed form inventory and disposed of. The nurse will check the expiration date of each medication before administering it.The facility policy Medication Labels Policy dated 12/17, did not address procedure for dating multidose medications once used.A facility policy on insulin administration/insulin pens was requested but not received.The policy Specific medication Administration Procedures Injectable Medication Administration dated 8/18, instructed staff administering an injectable medication to check the medication for expiration and to write the date opened and expiration date on the vial according to the table of shortened expiration dates for expiration date to use.

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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 was provided for 1 of 11 residents (R16) observed during dining while staff stood next to them while assisting them with eating.Findings include:R16's significant change Minimum Data Set (MDS) dated [DATE], identified R16 had diagnoses which included Alzheimer's disease, dementia, and diabetes mellitus. R16's MDS identified R16 was generally understood and could understand and was severely cognitively impaired.R16's group sheet no date, identified R16 required set up with cues and encouragement for meals and hydration.During an observation on 12/17/25 at 11:24 a.m., in the safe harbor dining room, there were 11 residents seated at four different tables.At 12:28 p.m., the covered food cart arrived on the unit and the meals were delivered to the seated residents.At 12:37 p.m., trained medication aide (TMA)-A was observed standing next to R16 and assisting her with eating.During an interview on 12/17/25 at 12:49 p.m., registered nurse (RN)-E stated she would expect all staff to sit in a chair next to a resident to help them with eating.During an interview on 12/18/25 at 1:00 p.m., the director on nursing (DON) verified all staff assisting a resident to eat should be seated for face-to-face contact. The DON stated it was not dignified to stand over a resident while helping them with their meal.The policy Assistance with Meals dated 2/2018, identified Residents who cannot feed themselves will be assisted with attention to safety, comfort and dignity.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote resident choice to refuse when medication was hidden in food for 1 of 5 (R46) residents reviewed for resident rights. In addition, the facility failed to ensure 1 of 2 residents (R34) with a vision deficit was assisted in selecting menu choices when they were unable to do so independently. Findings include: R46: R46's Resident Face Sheet printed 12/19/25, indicated R46 was his own responsible party. R46's quarterly Minimum Data Set (MDS) dated [DATE], indicated R46 had moderate cognitive impairment. Diagnoses included dementia, encephalopathy, and epilepsy. R46's care plan dated 7/23/25, identified R46 was non-complaint and refused medications at times. Interventions included accept resident right to refuse and show respect for resident decisions and to notify provider and hospice if medications refused. R46's care plan dated 6/26/25, indicated psychotropic medication was used and to administer per provider orders. R46's Hospice order dated 8/8/25, indicated okay to hide medications in food if needed. R46's progress notes were reviewed and indicated the following: - - 11/1/25, refused nighttime medications. Resident suspicious of hidden blueberries in his drink. - - 10/2/25, nighttime olanzapine again crushed and hidden in his coffee per order. - - 10/1/25, nighttime olanzapine crushed and hidden in his coffee per order. - - Orders to crush and hide medications in food appeared to be working well. R46's COVID-19 test consent form dated 12/16/25, was signed as a verbal consent given by R46. During an interview on 12/17/25 at 2: 48 p.m., registered nurse (RN)-F stated if a resident refused medications staff should come back and reattempt to administer the medications at another time. If the medications were still refused, then the refusal would be documented because residents had a right to refuse medications. Medications would never be hidden in food and the resident not told about the medications unless there was a provider order okaying the action. RN-F stated R46 had an order from hospice to hide medications in food so R46 would take them. RN-F stated R46 was his own responsible party and decision maker. During observations on 12/18/25 at 9:36 a.m., RN-D was observed crushing R46's medications and mixed them in a bowl of hot cereal. RN-D was then placed the bowl of hot cereal, with medications mixed in it, back on the food cart with the other resident meal trays. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/25 at 10: 38 a.m. the hospice registered nurse (HRN) stated hospice had provided an order on 8/8/25 that indicated it was okay to hide medications in R46's food and not tell him they were there. R46 had a history of refusing medications when he was told he was getting them, and the hospice agency and facility did not want him to refuse the medications. During an interview on 12/18/25 at 10:48 a.m., RN-D confirmed she had mixed crushed medications and hid the medications with hot cereal so R46 would not be aware they were there. The tray was then placed back on the food cart for somebody to deliver to R46's room. R46 would always refuse medications when administered to him and told they were medications to take. The facility did not want R46 to refuse the medications, so an order was obtained to mix medications with food when needed. R46 did not have a power of attorney and was his own person regarding decision making. R46's spouse had removed herself completely from R46's medical record. RN-D stated all residents, even confused/dementia residents who are their own person have the right to refuse medications. During an interview on 12/18/25 at 1:77 p.m., RN- G stated all residents, who were their own responsible party, or resident representative would have the right to refuse any treatment or cares, which included medication administration. There would need to be special steps taken before medications would be hidden in food and the resident not told about them. RN-G was unsure what steps would need to be taken During an interview on 12/18/25 at 3:48 p.m., the director of nursing (DON) stated residents, and resident representatives had the right to refuse any cares or treatment offered. R46 had no court orders in place that allowed the facility to give medications to R46 without telling him first and having the ability to refuse medications. Staff were expected to allow resident to refuse cares or treatments, document the refusals, and notify the provider of refusals. Facility policy Resident Rights and Notification of Resident Rights last reviewed 8/28/25, indicated a copy of the resident bill of rights was given to all residents at time of admission. One of the 45 resident rights included the right to refuse treatment.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure adequate privacy was in place prior to and after 1 of 1 resident (R75) had requested privacy measures be implemented for privacy during toileting and self-cares performed in bed.Findings include: R75's quarterly Minimum Data Set (MDS) dated [DATE], indicated R75 was cognitively intact with the diagnoses of multiple sclerosis, paraplegia, neuromuscular dysfunction of bladder, and constipation.R75's Care plan last updated 11/18/25, included interventions for bowel toileting program and resident self-performed intermittent catheterization. R75's care plan did not address R75's ?s privacy needs during self-care activities and/or bed pan use.R75's Physician Order Report: 1/1/22 to 12/19/25, included the following orders:Resident is okay to perform self-catheterization for neuromuscular dysfunction of the bladder.It is okay to leave medications at bedside for R to self-administer.Fleets enema once daily as needed rectal route for constipation. Ok for self-administration.A progress note entry made by licensed practical nurse (LPN-A) In R75's electronic medical record (EMR) included: Resident requested a privacy curtain. Resident feels that anyone could open their door and enter their room violating their privacy. Resident does have extensive toileting needs which does warrant increased privacy and validate this concern further - writer did let R75 know a request had been made.During an interview on 12/15/25 at 6:37 p.m., R75 stated because of MS, they had to have their bladder catharized, and they also had to use fleets enemas for constipation. They were able and preferred to do their own intermittent self-catheterization and administration of enemas which they did while in bed. R75 explained both tasks required them to open their legs wide apart, and this was very uncomfortable to do without having privacy between their bed and their room door. Without a privacy curtain, when their door was open, their bed was in full view. Staff did knock, but if they were performing selfcare and staff had to come in, as they did, R75 was completely exposed to everyone in the hallway. R75 stated they had asked multiple staff multiple times for a privacy curtain between the door and their bed, but nothing had been done. They could not recall everyone they spoke with but did remember talking to the nurse manager licensed practical nurse LPN-A. R75 stated they had tried to position their belongings as a shield, but it really was not adequate to protect them from being viewed from door/hallway. An observation confirmed R70 was viewable from the doorway/hallway when R75's door was open.During a follow-up interview on 12/18/25 at 11:14 a.m., R75 was in bed. R75 stated having a curtain or barrier was a matter of dignity and privacy nobody would want to have. It felt pretty awful to be in bed all exposed and afraid the door would open and expose them every time they performed self-care. They didn't feel it was too much to ask for something to protect them from being exposed when their room door was opened. During an interview on 12/18/25 at 11:59 a.m., the administrator and licensed social worker (LSW-B) were present. LSW-B stated they had just had a care conference with R75, and they didn't think that a privacy issue had been brought up. The administrator privacy curtains were not normally provided in single rooms, however their double rooms required privacy curtains so those were in place in all of their double rooms. The administrator did recall R75 had asked for a privacy curtain, and R75's request had been discussed, but with R75 having a single room the curtain had not been pursued. The administrator stated if it was something R75 wanted they and LSW-B could work with R75 on it. During an interview on 12/18/2025 at 1:27 p.m., LPN-A confirmed they had met with R75 a few months ago and at that time R75 had requested a privacy curtain or a shield of some sort for their room. LPN-A stated they had put the interaction in a progress note and reported it on to R75's care team for follow-up. LPN-A stated they didn't know the outcome of the privacy request but knew the administrator had been looped in by the care team. On 12/18/25 at 2:06 p.m., LSW-B reported a trifold curtain had been taken out of their office and placed at the door in R75's room, so now R75 had a privacy barrier in place. The facility policy Resident Rights and Notification of Resident Rights dated 8/28/25, identified residents had the right to respect, (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dignity, and privacy.The facility provided copy of the Minnesota [NAME] of Rights Minnesota Nursing Home and Boarding Care Home dated 12/4/15, sub-heading Treatment Privacy outlined residents shall have the right to respectfulness and privacy as it relates to their medial and personal care program. Privacy shall be respected during toileting, bathing, and other care activities of personal hygiene, except as needed for resident safety or assistance.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents were free of chemical restraints and utilized/documented nonpharmacological interventions prior to administering as needed psychotropic medications. The facility also failed to have a stop date for as needed psychotropic medications that were past 14 days and did not have a stop date documented. This effected 2 of 6 (R46, R69) residents looked at for unnecessary medications. Findings Include: R46: R46's quarterly Minimum Data Set, dated [DATE], indicated R46 had moderate cognitive impairment. Diagnoses included dementia, encephalopathy, and epilepsy. R46's care plan dated 12/8/25, indicated a psychosocial well-being concern related to potential for trauma related to my past military service and may become agitated or aggressive. Interventions included send to emergency room, notify hospice, analyze key times, places, circumstances, triggers and what de-escalates triggers. A care plan dated 6/26/25 indicated the use of psychotropic medication use which included risperidone, olanzapine and lorazepam. Interventions included monitor target behaviors daily. The care plan lacked what target behaviors to monitor for and what non-pharmacologic interventions to attempt prior to administering psychotropic medication. R46's Physician Order Report printed 12/19/25, indicated on 12/8/25 olanzapine 10 milligrams (mg) twice a day by mouth was started. Target behaviors were dementia with other behavioral disturbance, non-pharmacologic interventions included non-judgmental care and empathetic listening. On 6/25/25, lorazepam 1mg every 4 hours as needed (PRN) by mouth was started for anxiety/agitation. R46'S medication administration record (MAR) for December indicated Lorazepam was administered on the following dates with the following reasons: - 12/7/25 at 5:10 p.m., with prn reason of other. - 12/12/25 at 7:08 p.m., with reason of anxiety - 12/13/25 at 6:23 p.m., with reason of anxiety/agitation - 12/14/25 at 6:14 p.m., with reason of anxiety/agitation R46's MAR lacked any other documentation related to specific triggers that occurred to require the need to administer PRN psychotropic medications or what non-pharmacological interventions were attempted prior to administering medication. R46's progress notes were reviewed for the month of December and identified on 12/7/25 at 2:05 p.m., a male resident had entered R46's room. R46 proceeded to backhand the other resident on the left ear. The two residents were separated; a stop sign strap was placed on R46's doorway to prevent further entries without invitation. R46's progress notes lacked any other specific documentation related to triggers the resident had or nonpharmacological interventions attempted prior to administered lorazepam. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/25 at 2: 48 p.m., registered nurse (RN)-F stated prior to PRN psychotropic medications being issues there should be triggers observed from the resident and non-pharmacological interventions need to be attempted. Everything observed and attempted should be documented in the medical record, either in the MAR or the progress notes. RN-F indicated she had just arrived to work when R46 struck the other resident. Both residents were separated and taken to their own rooms. A stop sign was placed on R46's room right away and he was calm after that. RN-F stated R46 had remained calm after the incident, but an as needed lorazepam was still administered at 5:10 p.m., just in case and to head off any possible behaviors later that shift. RN-F stated that several times it is difficult to get R46 to take PRN psychotropic medications like lorazepam when he is in the middle of a behavior who several nurses, including me, would go ahead and given an Ativan in the evening before behaviors occurred and to keep him from having possible behaviors. Staff have not talked about a scheduled order for Lorazepam because the current order works. During an interview on 12/18/25 at 2:08 p.m., RN-G stated PRN medications should only be given when true behaviors/triggers are witnessed and only after non-pharmacological interventions were attempted first. If the non-pharmacological interventions work, then PRN medication should not be administered. Behaviors/triggers would then be documented either in the progress notes or the MAR, if medication was given. The non-pharmacological interventions would be documented in the progress notes. PRN psychotropic medication should never be administered just because, or to make a nurse's job easier. During an interview on 12/18/25 at 3:48 p.m., the director of nursing (DON) stated an expectation all nursing staff would document behaviors, nonpharmacological interventions and medication usage in the medical record. PRN psychotropic medications would only be used if needed and not for staff convenience. Facility policy related to PRN psychotropic medication was requested but not received. R69: R69's Face Sheet dated 12/19/25, identified R69 had diagnoses which included convulsion, dementia, anxiety, insomnia, pain, and depression. R69's quarterly Minimum Data Set (MDS) dated [DATE], identified R69 received antipsychotics, antidepressants, antiplatelets, and anticonvulsants medications. R69's care plan dated 9/16/25, identified mood state, interventions included medications as ordered, pharmacy consult monthly and as needed, observe for side effects of psychotropic medications and changes in mood. In addition, R69's care plan dated 6/4/25, identified he received psychotropic medications, interventions included to administer medications as ordered and to monitor for target behaviors. R69's Physician Order report dated 12/16/25, identified R69 received the following medication: lorazepam 0.5 milligram (mg) twice a day as needed for anxiety, with a start date of 12/2/25 and no end date. Consultant Pharmacist report no date, but signed by provider on 12/8/25, did not address the need for a stop date for the as needed lorazepam. (continued on next page)

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Benedictine Health Center	935 Kenwood Avenue Duluth, MN 55811

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/28/25 at 12:48 p.m., the director of nursing (DON) reviewed R69's electronic medical record and verified R69's as needed lorazepam order had no end date. The DON verified all as needed psychotropic medications required a start date and an end date. On 12/19/25 at 11:48 a.m., consultant pharmacist (CP)-F responded with the following email: Yes. For a resident prescribed PRN lorazepam (Ativan), an initial stop date of 14 days following initiation is recommended. At that time, the prescribing provider should evaluate the resident's use, clinical response, and ongoing need for therapy. Based on this assessment, the provider may determine an appropriate continuation plan and, if warranted, establish a subsequent stop date that does not exceed 180 days. The facility policy Psychotropic Medication Use dated 9/7/23, identified the following: PRN orders for antipsychotic drugs are limited to 14 days and cannot be renewed unless the attending providers evaluate the resident for the appropriateness of that medication.

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility staff failed to have qualified staff administer medications to a resident. This effected 1 of 1 (R46) resident reviewed for medication administration. Findings include: R46's quarterly Minimum Data Set, dated [DATE], indicated R46 had moderate cognitive impairment. Diagnoses included dementia, encephalopathy, and epilepsy.R46's care plan dated 6/26/25, indicated R46 received high risk medications. Interventions included administer medications per MD order and observe for side effects of medications.During observations on 12/18/25 at 9:36 a.m., registered nurse (RN)-D was observed crushing R46's medications and mixed them in a bowl of hot cereal. RN-D was then placed the bowl of hot cereal, with medications mixed in it, back on the food cart with the other resident meal trays. During observations on 12/18/25 at 9:48 a.m., the registered dietician (RD) was observed delivering R46's tray to the room and placed on the bedside table. R46's was observed to be asleep so RD left the tray on the bedside table and did not wake R46 up to educate on the medications or verify the right resident was getting the right medications. During an interview on 12/18/25 at 10:48 a.m., RN-D stated medication should only be gathered and administered to residents by a trained medication aide (TMA), licensed practical nurse (LPN), or RN. TMA's, LPN's, and RN's are the only staff members that are trained and qualified to gather and administer medications to residents appropriately and safely. Any other staff members would not have training on the 5 rights (right patient, right medication, right time, right dose and right route). Without that training residents would be at an increased risk of adverse effects from medications given to them.During an interview on 12/18/25 at 11: 52 a.m., the registered dietician (RD) stated she would assist at mealtimes to pass the trays more timely. The RD did remember passing R46's breakfast tray this morning. The RD was aware, based on care plan, R46 had medications hidden in their food and that medication might be on the breakfast tray when delivered. There was no verification prior to passing the tray to see if medications were present. The RD stated only staff members trained in medication administration should pass trays when medications are mixed with the food. The RD acknowledged she had no training in medication administration prior to that and did not have an understanding of accurate and safe medication administration policies.During an interview on 12/18/25 at 1:42 p.m., nurse assistant (NA)-E stated the staff who worked the cart would mix R46's medications with the food on the tray and then place it back on the food cart to be administered by somebody else. NA-E stated she had delivered R46's tray many times to his room with medications mixed with the food and left the food tray and medications in the room for R46 to take at a later time. NA-E confirmed she had no specialized training as a TMA to pass medications and understand the medication administration policies.During an interview on 12/18/25 at 3:48 p.m., the director of nursing (DON) stated only TMA's, LPN's and RN's had the appropriate training to gather and administer medications appropriately and safely. No other staff should be gathering or administering medications to residents.Facility policy Administering Medications last revised 8/31/23, indicated medications would be administered by licensed nurses (LPN, RN) or as otherwise delegated, trained associates (TMA). Medications would be administered following the 6 Rights of medication administration:a. Right Residentb. Right Medicationc. Right Dosed. Right Timee. Right Routef. Right Documentation

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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 morning cares including oral cares were completed for 1 of 3 residents (R62) reviewed for activities of daily living (ADLs), and who were dependent on staff for assistance with ADL cares.Findings include:R62's quarterly Minimum Data Set (MDS) dated [DATE], identified R62 had Alzheimer's disease and dementia. In addition, R62's MDS identified she required partial to moderate assistance with ADL cares.R62's group sheet undated, identified R62 required substantial assistance of one for dressing and substantial assistance of one for oral hygiene.R62's care plan dated 8/29/25, identified a self-deficit with bathing, grooming, and oral cares. Interventions included extensive assist of one to assist with bathing. The care plan did not address oral care.During a continuous observation on 12/17/25 starting at 7:41 a.m., and ending at 10:55 a.m., nursing assistant (NA)-F assisted R62 with clothing choices, put Tubigrips (a brand of elastic bandage) on her legs, gripper socks, pants, and shoes. NA-F rang the call light for help (NA)-G entered and assisted NA-F with a brief change, they then assisted R62 into a wheelchair, NA-F combed R62's hair and she was brought to the dining room for breakfast.-at 9:03 a.m., R62 remained in the dining room at the table, she was done with breakfast.-at 9:10 a.m., R62 talked about leaving staff asked her if she wanted to go the exercise group, she declined. No staff offered to bring her to her room to brush her teeth after breakfast.-at 9:28 a.m., staff brought R62 to the exercise activity.-at 9:43 a.m., staff brought R62 to the dining room for a manicure.-at 10:08 a.m., R62 went into her room alone.During an interview on 12/15/25 at 1:47 p.m., family member (FM)-E stated they did not think R62's teeth were being brushed twice a day.During an interview on 12/17/25 at 10:30 a.m., NA-F stated there were two NAs from 6:00 a.m. to 10:00 a.m., and offered that it was hard to get everything done for residents. NA-F stated morning cares included getting the resident's brief changed and dressed. NA-F stated completion of oral care was dependent on if they had time, otherwise oral care should be done after breakfast. NA-F verified she did not complete oral care for R62 during morning cares or after breakfast.During an interview on 12/17/25 at 10:55 a.m., trained medication aide (TMA)-A stated they could use more help, verified they can't get morning cares completed with one- and one-half nursing assistants.During an interview on 12/17/25 at 12:51 a.m., registered nurse (RN)-E stated the staffing was one TMA and one- and one-half NAs. The one half NA was scheduled from 6:00 a.m. to 10:00 a.m RN-E verified morning cares included face washing, hand washing, oral care, clean clothes, and peri-cares. RN-E stated she would expect this to happen every morning. During an interview on 12/18/25 at 12:52 a.m., the director of nursing (DON) stated he would expect staff to follow the group sheet for cares. The DON verified face washing, hand washing, oral care, toileting, and incontinence cares were all part of morning and evening cares. The DON verified it was important to provide oral care to help residents keep the teeth the have. The policy Activities of Daily Living dated 6/2021, identified the following, Residents unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, personal hygiene, elimination, communication and mobility. The policy identified hygiene as bathing, dressing, grooming, and oral care.

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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 record review the facility failed to ensure a locked door on the secure memory care unit had a functioning alarm to prevent residents at risk for elopement from leaving unobserved. This affected 1 of 2 residents (R100) reviewed for elopement risk. Findings include:R100's admission Minimum Data Set (MDS) dated [DATE], identified R100 had diagnoses which included macular degeneration (an age-related eye disease that damages the macula, causing loss of sharp, central vision needed for reading and driving), hearing loss, and cognitive communication deficit. In addition, R100's MDS identified he was severely cognitively impaired, had behaviors, and wandered. R100's MDS identified a wanderguard was in use daily.R100's care plan dated 12/12/25, identified R100 had cognitive loss with exit seeking behavior. Interventions included to distract with activities and a secure memory care unit with specialized programming. R100's care plan also included behavioral symptoms, wandering towards doorways and elevators. Interventions included to approach from the front, walk in step with him before redirecting, wanderguard use, and to provide comfort measures for basic needs (snack, redirection, activities).R100's group sheet undated identified he wandered but was easily distracted.R100's nursing progress notes dated 12/14/25 at 3:13 p.m., Resident exit seeking. Resident got through back door. Back door alarm is broken. Resident able to get through without code. Staff redirected resident and then he continued to exit seek down the other hallway. Writer let nurse know.R100's nursing progress note dated 12/5/25 at 10:27 p.m., identified the following: He is wearing a wanderguard on his left ankle, as he attempts to get on the elevators and leave the unit at times.Behavior monitoring sheets:12/6/25 at 1:07 p.m., Pt has been wandering consistently throughout the day, both exit seeking and general wandering. Several other pts reported seeing him try to come into their rooms. Have been keeping a watchful eye on him, he has tried to open the doors to the stairwell and almost snuck on the elevator behind a visitor (does have a wanderguard on).During observations on the memory care unit on 12/15/25 between 12:05 p.m., and 7:00 p.m. the back door alarm was not heard to alarm despite dietary staff using that entrance/exit. During an observation on 12/16/25 at 2:04 p.m., R100 was observed pushing the back door to the memory care unit open, he was able to get part way out of door before the director of nursing (DON) saw him and pulled his wheelchair back into the unit. No alarm sounded.During an observation and interview on 12/17/25 at 8:33 a.m., maintenance worker (MW)-B was observed working on the back door to the memory care unit. MW-B stated he'd heard that morning that the alarm was not working. MW-B verified the door was not alarming or locking. MW-B verified staff had placed a chair in front of the exit and he was working on putting an audible alarm on the door, he stated he did not know how long it had not been working (locking or alarming). During an interview on 12/17/25 at 8:46 a.m., registered nurse (RN)-E stated she was not sure how long the door had not been locking, then said Saturday but she had learned it was not functioning on Monday, and she informed the administrator. RN-E stated they were just keeping a close watch on the door.During an interview on 12/17/25 at 2:00 p.m., environmental services director (EVS)-G stated the door (back exit to the memory care unit) had not been locking since the end of November. He was not sure how maintenance staff had been informed the door was not alarming on 12/17/25. EVS-G verified there was a chair in front of the door and stated it was not okay to place a chair in front of an exit door. EVS-G verified if a resident got through the door, they could potentially exit the building (they would have to take an elevator to the first floor) and no alarms would sound at the first floor exit to the outside of the building.During an interview on 12/17/25 at 2:21 p.m., trained medication aide (TMA)-A stated she was not sure how long the back exit door to the memory care unit had not been working locking or alarming. TMA-A stated they were told to watch more closely and count their residents.During an interview on 12/17/25 at 1:01 p.m., RN-E stated they had been instructed to place (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a cart in front of the back exit door. RN-E verified there was a hallway that led to an elevator that went to the third floor or down to the first floor where there was an exit to the outside of the building.During an observation on 12/17/25 at 1:11 p.m., with EVS-G were able to exit the memory care unit, get on the elevator, take it to the first floor and go out a door to the outside of the building.During an interview on 12/18/25 at 2:32 p.m., the administrator and executive director verified the back door to the memory care unit was not locking, they also verified it was not acceptable to place furniture in front of the door as a deterrent to residents using it due to safety concerns. They verified the staffing level for the unit was not changed while they were waiting for parts to fix the door.The policy Elopement dated 10/14/22, identified the purpose was To provide a safe and least restrictive environment for residents. To maintain the safety of residents who are at risk of wandering and/or active elopement. In the post-investigation section questions that needed to be asked and answered were: a. Were the alarm systems working properly?b. Were all internal and external doors visually checked?c. Were there any deficient practices or system failure?The policy did not specifically address the memory care unit and safeguards in place for residents.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview and document review, the facility failed to ensure the nursing staff posting included the facility name and was updated with changes in staffing. In addition, the facility included the director of nursing and the nurse managers (who were not responsible for direct resident care) in the total hours worked. This had the potential to affect 96 residents and their visitors.Findings include:On 12/15/25 at 4:22 p.m., the hours posted were as follows: Staffing Hours report for Nursing at Duluth-SNF dated 12/15/25, census was listed as 93. The posting was in sections nursing assistant and trained medication aide totaling 93.25 hours. Section for licensed practical nurse totaling 32 hours. Section for registered nurse included the clinical managers (two), the director of nursing and two registered nurses with the total hours as 40. The director of nursing and the clinical manager hours were included in the total hours for nursing care.A review of the DON's job description dated 2/2019, identified they were responsible for leading, planning, supervision to provide effective nursing services. In addition, to provide administrative and clinical leadership.A review of the clinical manager's job description dated 2/2019, identified the clinical manager is a clinically competent registered, professional nurse who assumes accountability and responsibility for a particular unit of resident/patient and the direct care staff. Effectively manages the care process of the residents/patients by coordinating and overseeing the provided care and competency of those entrusted with the responsibility. The job description identified the role as supervision.On 12/18/25 at 1:39 p.m., the director of nursing (DON) verified the staffing hours were posted daily but no changes were made on the posted sheet for residents and visitors. The DON stated those changes were noted elsewhere. The DON verified his hours as well as the clinical manager hours were included in the total worked hours for direct care. The DON also verified the actual name Benedictine Living Community of the facility was not part of the posting, instead the name was listed as Nursing at Duluth-SNF.On 12/18/25 at 2:11 p.m., the human resource director (HRD)-K stated she was making the nursing schedule for now. HRD-K stated they did not know why the name of the facility wasn't on the posting for nurse staffing. HRD-K verified changes were not made on the actual posting for residents and visitors to see. HRD-K verified the DON, and the clinical managers daily responsibilities did not include direct resident care.The Staffing and Daily Work Assignments dated 9/2018, did not address the daily nurse staff posting but did however, identify licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services.The annual facility assessment dated 8/2025, in the section on Staffing Plan identified the director of nursing and the nurse managers as other nursing personnel (e.g., those with administrative duties).